Gender, Participation and the Right to Health: Health Committees in Cape Town, South Africa

A Dissertation by

Janet Austin

ASTJAN006

Submitted to the University of Cape Town

Faculty of Health Sciences

School of Public Health and Family Medicine

in partial fulfillment of the degree of

Master of Public Health

E-mail: **janetaustinsa@gmail.com**

Date of submission: March 2017

SUPERVISORS:

DR. MARIA STUTTAFORD

DR. ALEXANDRA MŰLLER

Declaration

I, Janet Sarah Austin, hereby declare that the work on which this dissertation is based is my original work (except where acknowledgements indicate otherwise) and neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signed by candidate

Signature

12/03/2017

Date

Abstract

Community participation is now widely recognized as an integral part of health systems and the right to health. Health Committees are an example of participation, influenced by multiple social factors, yet little research has covered the impact of gendered power relations in health committees themselves. Committees are also deemed to be accountability structures, aiming to bolster the efforts of an overburdened health system and aid in responding to the need for often under-resourced services relating to women's and sexual orientation and gender identity (SOGI) minorities' health and sexual reproductive health rights. Current literature affirms the social mobilisation of communities via participation structures, with all committee members needing to be empowered in their roles to provide a greater reach and platform for marginalised groups as both committee and community members.

A qualitative, exploratory study was undertaken to answer the question: What is the role of gendered power relations in Health Committees in the Western Cape? Multiple methods were used during March to December 2015 that included observation of Health Committee meetings, group discussions and in-depth interviews. A Gender-based Analysis using African Feminist Theory was applied, with Connell's 1987 theory of gender and power as well as considerations of community participation as a function of citizenship.

Findings showed that the perception of gender equality and gender relations amongst Health Committees remains largely misunderstood and unaddressed. The Draft Western Cape Health Boards and Facilities Bill of 2015 provided an unstable political backdrop during fieldwork. Democratic group processes did not nullify manipulation of gender roles, and a disconnection between leadership positions and influential agents could be seen. This was accompanied by no notable gender bias concerning health need foci and a non-discriminatory outlook towards committee participants or service recipients, however there was no action to engender such claims, such as special training or

materials to support sexual and gender minorities. Adequate representation and reinforcing accountability of Health Committees remains a challenge.

Gender mainstreaming in inclusive policy needs to be operationalised at facility level, and gender-sensitivity training for Health Committees is a viable approach with which to address the continuing poor policy to implementation problem. The Western Cape Health Boards and Facilities Act of 2016 shows some promise towards recognising and broadening committee governance and diversity. Women and SOGI minorities must be supported in leadership roles to strengthen scaling up efforts and enable the Health Committees to function as truly accountable and participatory instruments for public health.

Acknowledgements

I wish to thank all of the members of the passionate and devoted Health Committees who participated in this study, for giving their time and trust to explore this work. Thank you to the sub-district managers on the Cape Metro Health Forum who saw value in the project and granted me access to the committees.

I would like to thank the Learning Network for Health and Human Rights for giving me the opportunity to take this topic on and contribute a small piece of a significant puzzle.

I wish to extend my sincerest gratitude to Dr. Maria Stuttaford and Dr. Alexandra Müller for their supervision of the project and production of this dissertation. Their seasoned guidance, invaluable feedback, patience and support throughout has inspired much growth and will never be forgotten.

Dedication

To my mother, a role model who has taught me strength and perseverance in all things, whose love and support traverses many kilometers.

To my stepmother Helen, for her inspiration and encouragement.

And to my partner Persephone, who patiently supported me over this period and brings magic to my life.

Table of Contents

Table of Tables

Part A: Protocol

Part C: Journal Manuscript

Part A: Protocol

1. Introduction

1.1 Research Justification

Inequality in access to health care services is still rife 20 years on from the introduction of a democratic South Africa. Progress has notably been stunted around women's health and sexual reproductive health rights and services due to overburdened facilities lacking adequate resources. The district health care system and community based health care initiatives have meant some improvement in facilitating community healthcare needs, with increased community participation in the form of Health Committees. There has been much investigation of late around the success and failures of Health Committees (HCs) and their efficacy in aiding the realisation of a community's right to health (Loewenson, Rusike & Zulu, 2004; Glattstein-Young, 2010; Haricharan, 2012; Frumence, Nyamhanga, Mwangu & Hurtig, 2014). The proposed research will investigate a gap between Health Committees and the promotion of the right to health, particularly concerning gendered power relations. The subtle gendered power dynamics amongst community participation avenues need to be addressed in order to realise how services are prioritised or lacking, how community needs are met and the source of the attitudes towards gender sensitive health services. Community participation outlets cannot fulfil all their undertakings effectively without a fully examined social context and appraisal of how equality and non-discrimination are upheld within their own structures.

2. Research Objectives and Questions

2.1 Objectives

- To investigate HCs knowledge and understanding of gender-sensitive health care services.
- To explore how gendered power relations influence how Health Committees operate.
- To explore how gendered power relations in HCs influence participation in health care service provision.

2.2 Questions

Main Research Question:

What is the role of gendered power relations in Health Committees in the Western Cape?

The main objective of the research is to explore the gender composition, gender roles and gendered power structures within Health Committees and their impact on the role and functioning of Health Committees.

Sub-questions:

1) What is the perception of gender equality of Health Committee members in the Western Cape?
2) How does gender impact on the role and functions of the Health Committees (as stated by the Health Committees)?
3) How do gendered power relations influence the health issues in which Health Committees engage?

3. Operational Definitions

Health:

The World Health Organisation defines health as “a complete state of physical, mental, emotional and social well-being, and not merely the absence of disease or infirmity” (WHO, 1948)

Human rights:

Human rights are the “recognition of the inherent dignity and the equal and inalienable rights of all members of the human family” (UN, 1948) by virtue of being human.

The Right to Health:

The right to the "highest attainable standard of health" (ICESCR 1966; General Comment No 14, UN, 2000). This includes the principles of accessible, available, appropriate health care and quality in standards of the determinants of health and health care. This includes promotion of gender equity with the adoption of a gender perspective, and the elimination of discrimination against women with prioritisation of sexual and reproductive health rights (General Comment No 14, ICESCR, 2000).

Gender:

The socially constructed norms and behaviours associated with a person's sex, or biological characteristics (APA, 2011). Most prevailingly considered a binary construct (male and female) but is also understood as being on a continuum or non-binary (such as male, female and transgender) (Friedman, 2006).

Gender Mainstreaming:

A multi-government sector and agency collaboration effort to achieve gender equality, with integrated policies and strategies with particular policy tools, such as Gender-based analysis and accountability mechanisms (McNutt, 2010).

Gender-based Analysis:

"Gender-based analysis is a process that assesses the differential impact of proposed and/or existing policies, programs and legislation on women and men. It makes it possible for policy to be undertaken with an appreciation of gender differences, of the nature of relationships between women and men and of their different social realities, life expectations and economic circumstances. It is a tool for understanding social processes and for responding with informed and equitable options" (Status of Women Canada, 1996, p.4).

Community participation:

This entails “active and informed participation in the identification and development of health policy, as well as implementation and accountability” (Potts, 2008; p.4) in that community members may be involved in health agenda setting and strategy to meet their self-determined health needs, with accountability mechanisms to secure their rights.

Health Committee:

The South African National Health Act 61 of 2003 (Department of Health, 2004) espouses Health Committees as being a bridge between health facilities and the community which they serve. They are generally composed of the health facility manager, a ward councillor and members of civil society (Haricharan, 2012). This definition is not all-inclusive and highlights the custodial functions of Health Committees whilst others emphasise the managerial and advocacy components of their role as a bottom-up feedback mechanism for implementing health strategy (TARSC, 2006; 2011).

4. Methods

Critical realism is an epistemological persuasion which holds that reality is stratified, separating the real from the empirical, and events from the structures which produce them (Jefferies, 2011). Adopting this outlook means challenging researcher assumptions and allowing an interpretation of reality to be offered to them by the respondents. The research, coloured by its context, is to be informed by the experiences and contexts of the participants, namely African experiences and how African champions of local causes are represented. This is integral to African Feminist Theory, a particular approach to feminist theory in an African paradigm, where Africans are the authors and not merely subjects in need of explaining or saving (Sachikonye, 2010). It is pertinent to the everyday realities of African women where feminist theory should not be separated from practice

and overcoming materialistic oppression cannot be superseded by other theoretical concerns such as political hierarchies, being typical of western feminism (Jacobs, 2013). This theory also permits the research to adopt an interpretive framework using grounded theory to derive meaning.

4.1 Study Design

A qualitative, flexible research strategy has been selected as appropriate for an exploratory research purpose (Robson, 2011). Multiple methods will be used. Firstly, after initial document reviews of Health Committee and facility policy, observations of Health Committee meetings will be carried out followed by group discussions with all Health Committee members, which will inform the questions to be put to selected Health Committee members in in-depth interviews. A micro level analysis of individuals within Health Committees will be regarded as representative of the Health Committee functioning as a whole.

4.2 Study Setting

Provincial and district level health facilities in the Western Cape are bound by policies such as the National Health Act, 61 of 2003; the Health Professions Act, 56 of 1974; Promotion of Access to Information Act, 2 of 2000; South African Good Clinical Practice Guidelines (2006), and the National Core Standards for Health Establishments in South Africa, 2011 to name a few. These policies should guide the services provided and act as references for the work of the Health Committees. There is a legislative gap surrounding HCs in the Western Cape. In 2008 a draft policy framework for community participation in health was drawn up but never came to pass, being thrown out in 2011 (Haricharan,2013). There are over 50 Health Committees currently in the Western Cape, and the research may be conducted at three sites pending further arrangements.

4.3 Population and Sampling

4.3.1 Negotiating Entry

In order to negotiate entry into the selected Health Committees and the communities in which they are based, interviews with organisational gatekeepers and key informants will be held prior to the data collection phase. The community gatekeepers and other key informants will be purposefully sampled due to their involvement with the Learning Network and the Cape Metro Health Forum (CMHF). This will include two key informants from the CMHF, one of whom will be the Chair of the CMHF who is on the LN Executive Committee and with whom there is a well-established working relationship. Permission will be sought from her to contact the HCs. Other sources of key informants will be two from Cape Metro Health and two from Western Cape Provincial Health. The Learning Network is also well allied with the MEC for Health, Professor Nomafrench Mbombo, another key informant to be approached. As the project's flexible design is using qualitative methods, snowball sampling will be employed whereby each of the seven outlined key informants will be asked if there is one other person they recommend be interviewed. This produces an estimate of 14 maximum key informant interviews.

4.3.2 Health Committees

The sample of Health Committee members will be selected via purposive, convenience sampling, whereby members will be identified through the Learning Network in feasible locations. Access may be negotiated through Learning Network members or activities through their monthly meetings with trainers as part of their Health Committee training program. Care will be taken to invite participation from HCs so that no HC is overburdened. Three Health Committees will be approached for inclusion in this study, with the intention of reflecting diverse socio-economic circumstances of the Western Cape. The amount is limited due to the feasibility of the project at Masters' level. If some members object to the researcher observing committee meetings (which is

the first data collection method to follow), then another Health Committee will be approached for the study altogether, as the meeting observations should not be left out for one committee, but included for another. Permission to observe meetings (as well as carry out other study components) will be sought by the researcher when she is invited to a first meeting by a key informant to introduce her research. It can then be clarified whether or not all members agree to observations, and therefore inclusion of the committee, in the study.

4.3.3 Health Committee Members

The size of HC ranges roughly between five to fifteen members. Despite the varying size of Health Committees, purposive convenience sampling will be employed and all Health Committee members may potentially participate in the group discussions. Thereafter a cross section of five selected members from each HC will be approached for in-depth interviews, including the HC Chair, to reflect the diversity of HC members across gender, race, education and background. If a key informant is also an HC member, they may participate in the group discussion and make themselves available for a further in-depth interview should the researcher decide to choose them after the group session. It is estimated that there will be a maximum of 15 in-depth interviews. The minimum selection criteria include age of more than 18 years and having been a HC member for at least one month. The short minimum period is due to the “revolving door” membership of some HCs, and should be sufficient for gauging the nature of participation in the committee. Interviewees may be full or part-time members, and will, ideally, have been part of the group discussion, however it is not compulsory for any participant to attend all research activities.

4.4 Data Collection

Table 1. Research Questions and Applied Methods

Research Question	Data Collection Methods
1. What is the perception of gender equality of Health Committee members in the Western Cape?	Observations In-depth interviews Group discussions
2. How does gender impact on the role and functions of the Health Committees (as stated by the Health Committees)?	In-depth interviews Group discussions Observations
3. How do gendered power relations influence the health issues in which Health Committees engage?	Observations Document Review In-depth interviews Group discussions

4.4.1 Document Review

Content analysis of documents, or document review is an unobtrusive data collection method which would be a reasonable starting point to inform the research. Documents of interest would include health practice policy of the Health Committee, mission statements and minutes of previous meetings. As static records of activity, they cannot be influenced by the researcher and may be used to validate other methods and findings (Robson, 2011). Themes detected in interviews may become visible in documents later on in the analysis process.

This method relies on availability and accuracy of the relevant material. As no health policy practice guide has been issued by the Department of Health, meeting minutes or task sheets or records may be sourced with the permission of the Chair of each HC. Triangulation of methods would prove most beneficial as elements of the documents may be unclear or highly specific to the context and may need further verification. As the researcher will be interviewing at least one member of the committee the documents pertain to, there are other data sources to combat this. The documents will reveal male/female composition of HCs, who the Chair, secretary, treasurer are and

different roles men/ women have, if women present, do they participate etc. The review will cover documents from the establishment of the committee, but not further than the past five years, until the end of the data collection period.

4.4.2 Observations

Using observation methods as an introductory data collection method is an intuitive choice for research around social dynamics, which sometimes need to be seen to be believed. The method provides a complement to other methods as they fill the gap between what respondents report doing and what they actually do (Robson, 2011). It will be most useful to observe Health Committee meetings and note the gender composition of committees, role and task division, dynamics between members, where dominance lies and where consensus is built or concerns ignored. These may be aspects which cannot be articulated by members themselves.

Validity may a primary cause for concern in observations, as the extent to which the observer may influence a behaviour or elicit the Hawthorne effect in the observed may be unknown and difficult to predict. It may be challenging to remedy as being uninvolved may appear disconcerting and too much involvement could sacrifice the role of an objective researcher. The researcher will attend the Health Committee meetings as a guest, with clear research intentions, but will not intervene. Flexibility of the research design allows for this development. Observations can be very time-consuming however the stipulated meeting time-frame should allow for some indication of the time commitment.

4.4.3 Group Discussions

Semi-structured group discussions or group interviews are another potential source for rich responses and have the natural advantage of being inclusive regardless of literacy levels and

encouraging input from normally unlikely or unwilling participants (Robson, 2011). It may be useful for offsetting the research questions or yielding more varied responses as participants have the opportunity to hear other perspectives, proving to be a highly productive method. Group dynamics can be exploited here to assess where there is some consensus or not around certain issues. Group facilitation will require a particular skill-set once again, however with the experience the researcher has in working with groups, relevant facilitation skills should aid the discussion of more contentious topics such as power dynamics.

To keep group sessions manageable yet fruitful, the number of questions would need to be limited. There can be a tendency to give more credence to strong opinions supported by groups or to try to generalise the findings to wider population. The pre-selection of questions based on in-depth interviews may increase relevancy of such issues and professionalism of the facilitator as a researcher should safeguard against this. Facilitator training should also be able to contain any conflicts within the group, and address confidentiality, as the group dynamic may weaken the bond of confidentiality amongst the group members (Robson, 2011).

The use of diagrams and visualisation methods (UNICEF, 1993) in the group discussions will also add legitimacy to findings though participatory exercises of self-expression and personal representations of current realities (UNICEF Bangladesh, 1993) (See Appendix D).

4.4.4 In-depth Interviews

Face-to-face interviews have the advantage of direct inquiry over conjecture from observations, and so can elicit rich data and enlightening insights into a phenomenon. This is most appropriate for the research questions set out previously as they are exploratory questions with likely complex and detailed answers that do not fit neatly into a few categories. They also allow for contingent modification of enquiry in response to new or interesting points raised in the interview, for further

exploration than is possible in more static methods such as surveys. This is especially relevant for a topic of this nature, which may elicit strong opinions or even reveal how inexpressible yet tangible certain issues around gender and power relations are when working in Health Committees. The adept interviewer can also pick up on non-verbal cues which may amplify or refute spoken responses, especially as the topic questions may veer into sensitive or contentious arenas, where respondents may find it difficult to answer or hide emotive reactions such as frustration (Robson, 2011). This may not prove a challenge as questions will be condensed from previous in-depth interviews in order to select the correct foci for the group sessions.

This data collection method does then require some kind of expertise or skill-set of the interviewer, with some interview technique training, sensitivity to verbal and non-verbal cues and good interpersonal skills. This method does fall prey to its subjective nature and biases must be kept at bay. Interviews may be very time-consuming and must be kept to a reasonable length at the agreement of the participant, and for the betterment of the data collected. As a qualified social worker with interviewer experience, the researcher will endeavour to contain interviewee expectations and be conscious of potential bias.

5. Analysis

A thematic analysis of observation notes, the document review, interview transcripts and group discussion transcripts and materials will be undertaken, guided by schema of a gender-based analysis framework and themes of African Feminist Theory. Interview and group discussion recordings will be translated if applicable and transcribed. After immersion phase of reviewing the data continuously, a system of codes will be built around the research questions and deciphered and grouped from the data (Ulin, Robinson and Tolley, 2005). From the initial line of coding, they will be further categorised into various strata such as conceptual codes, participant perspective codes

and setting codes from emerging themes (Bradley, Curry and Devers, 2007). The data will then be displayed as themes are unpacked more closely to yield any groupings or diversions within themes. At this stage the codes and data will be reviewed and choice of codes discussed with the research supervisors for rigour purposes. The resulting data will be synthesised for overall findings. Coding and data analysis managed using the Nvivo Data Analysis Software for convenient documentation and processing of the analysis.

6. Rigour

Lincoln and Guba's (1985) constructs for assessing rigour in qualitative studies will be employed. Credibility, is crucial in validating the data collection tool's ability to retrieve the desired data and to determine the congruence between findings and reality (Shenton, 2004). As there is no gold standard tool for uncovering gender and power relations in a human social or working group, the well-established in-depth interview and other qualitative methods are appropriate to elicit such data.

Dependability is concerned with the ability to elicit similar findings in similar settings, using the same methods. Lincoln and Guba (in Shenton, 2004) espouse the mutually beneficial link between dependability and credibility, and that overlapping of methods can help to ensure both, as the project intends. The process is outlined in detail for future replication to aid understanding in key areas outlined by Shenton (2004) as the research design implementation, operational process of data collection and reflective evaluation of the method of inquiry.

Confirmability ensures that findings are the respondent's realities and not purely researcher perspectives. Triangulation of four data sources will play a key role is preventing investigator bias as far as possible (Shenton, 2004). Reflexivity of the researcher will be essential in showing transparency, awareness of limitations and predisposing attitudes. The researcher will keep a

reflexive journal of all encounters with the study sample and environment throughout the research process to document such awareness. This will form part of the audit trail for the research, along with interview transcripts and any work produced from group visualisation exercises (Lincoln and Guba, 1985, in Ulin, Robinson and Tolley, 2005).

Transferability must be applied with caution so as not to discount contextual factors, as they are inextricable from understanding findings. The sample being part of a wider population, where similar projects using the same methods could be conducted, lends some external validity to an extent (Shenton, 2004).

7. Impact on Health Services and Participants

Table 2. Estimated Burden for Participants and Services

Burden	Participants
Time requirements	+/- 1 hour for in-depth interviews 2 hours for group discussions
Space requirements	None, or discretion regarding a private location for in-depth interviews
Equipment requirements	None

8. Ethical Considerations

8.1 Risks

The study should pose no threat of harm to the participants, Health Committees as a whole, health facilities as study sites, or the researcher. Precautions will be taken to prevent any compromised confidentiality or reputational risks. Open discussion of committee stumbling blocks could also potentially lead to some disharmony amongst committee members, however it will be reinforced

that the research tasks are to benefit the committee as a whole as well as others, and that blame and arbitration exercises are not the aim. Should any emotional distress or the desire to bring forward disputes over committee functioning arise, a referral system will be in place to avail participants to the services of relevant health professionals, or to appropriate channels in the Cape Metro Health Forum.

8.2 Benefits

The potential benefits of the study are both at an individual and group level. Discussing the 'invisible issues' may bring some form of catharsis or relief for participants who may grapple with limitations upheld by the status quo, with few avenues to address them. Individual and group 'calling out' of these issues may bring about an opportunity for empathy and greater consideration between fellow Health Committee members. Even if this does not lead to immediate institutional change, the potential for increased solidarity is valuable. This is part of a larger study. Results will feed into final report and recommendations for training and development of HCs.

9. Limitations

The participants and Health Committees selected are only those connected to the Cape Metro Health Forum in urban areas of the Western Cape, and so may not be truly representative of all Health Committees in the Western Cape Province. Timing, budgetary and logistical constraints also determine the small sample size and time sensitive data collection periods. This may potentially mean less than exhaustive data gathering as the momentum of sessions may be cut short. Being an exploratory study, it cannot provide immediate, actionable solutions to participants around problems distilled from the findings, and so it would be necessary for follow-up work to investigate efforts to this end.

10. Anticipated Gains in Knowledge

- The study aims to add to the body of literature on the theme matrix of gender and the right to health, and community participation.
- It also endeavours to evaluate gendered relations in Health Committees and identify potential dynamics that may hinder the committee's full potential.
- It will further reflect how policy and management systems are failing to promote and monitor progressive, gender-sensitive services and how this could be addressed.

11. Dissemination

The findings of the study may be applicable to many stakeholders in considering dissemination. The final report summary will be sent to all participating, Health Committees and any participants upon request. A condensed report of findings and recommendations will also be available. The findings will be presented to the LN which consists of civil society organisations as well as Health Committee members, and will further be available on other LN communication networks such as the website and accessible to the mailing list. The findings will also be presented at the Cape Metro Health forum plenary or stakeholder meeting for the benefit of remaining cognisant of gender and power inequalities in Health Committees. The study findings will also form part of an evaluation report to be sent to the International Development Research Centre (IDRC). Following this, an article for publication will be disseminated through a peer-reviewed journal to reflect insights into gender and the right to health within Health Committees.

12. Budget

12.1 Sources of Funding

The study is being privately funded by the researcher with additional contributions made by the Learning Network. The total budget allocated is approximately R25 000 for the study process and materials. This brings no publication restrictions or contractual obligations, with the agency of the researcher upheld. Health facilities, Health Committees and individual participants will bear no costs for their involvement.

12.2 Budget Estimate

Table 3. Estimated Research Budget

Item	**Cost (ZAR)**
Transport for interviewer over 3 months	3600
Research Tools • Audio recorder • Transcription • Translation	10 000
Interpreter	5000
Stationery and Supplies • Photocopying and Printing • Flip charts • Stationary • Refreshments	800
Telecommunications Scheduling meetings with key informants	150
Dissemination	450
Grand Total	20 000

13. Timeline

Table 1. Gantt Chart

	2014										2015							
Month: / Activity	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A
Literature Review	x	x	x	x	x													
Proposal Write-up				x	x	x	x	x										
Ethics Approval (UCT)									x	x	x							
Provincial Approval									x	x	x							
Key Informant Interviews and negotiating access									x	x								
Fieldwork – Observations, Interviews and Group discussions											x	x	x	x				
Analysis and Feedback											x	x	x	x	x			
Write up													x	x	x	x		
Ethics Review															x			
Coursework	x	x	x	x	x	x	x	x	x									
Thesis Submission																	x	
Feedback and Dissemination																		x

14. References

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay and bisexual clients. *American Psychologist*. **67**(1):10-42.

Bradley, E.H., Curry, L.A. and Devers, K. J. (2007). Qualitative data analysis for Health Services research: Developing taxonomy, themes and theory. *Health Services Research* **42**(4): 1758-1772.

Department of Health (2004). South Africa National Health Act No. 61 2003. *Government Gazette No. 26595* South Africa.

Friedman, A. (2006). Unintended consequences of the feminist sex/gender distinction. *Genders,* [Online] 2006 (January) Available at: http://www.colorado.edu/gendersarchive1998-2013/2006/01/02/unintended-consequences-feminist-sexgender-distinction [Accessed 2 October 2014].

Frumence, G., Nyamhanga, T., Mwangu, M. & Hurtig, A-K (2014). Participation in health planning in a decentralised health system: Experiences from facility governing committees in the Kongwa district of Tanzania. *Global Public Health* **9**(10): 1125-1138.

Glattstein-Young, G. (2010). Community Health Committees as a vehicle for participation in advancing the right to health. University of Cape Town, Unpublished Master's Thesis.

Haricharan H. (2012). Extending participation: Challenges to Health Committees as meaningful structures for community participation. Human Rights Division, School of Public Health, University of Cape Town.

Haricharan, H. (2013). Rapid Appraisal of Health Committee policies in South Africa (draft). University of Cape Town

Jacobs, B. (2013). Unbounded by theory and naming: Survival Feminism and the Women of South African Victoria Mxenge Housing and Development Association. *Berkeley Journal of Gender, Law & Justice*. **26**(1): 19-77.

Jefferies, B. (2011). Critical Realism – An Empirical Realist Critique. Working paper 11-03. Manchester Metropolitan University Business School.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing Trustworthiness (pp. 289-331), in *Naturalistic Inquiry* Beverly Hills, CA: Sage Publications.

Loewenson, R., Rusike, I., and Zulu, M. (2004). *Assessing the Impact of Health Centre Committees on Health System Performance and Health Resource Allocation* (Discussion Paper no. 18). Harare: Equinet. [Online] Available at: www.equinetafrica.org [Accessed 12 November 2014].

McNutt, K. (2010) An Integrated Approach to Gender Equality: From Gender-Based Analysis to Gender Mainstreaming. Johnson-Shoyama Graduate School of Public Policy, University of Saskatchewan, Canada. February, Issue 2: 1-13.

Potts, H. and Hunt, P. H. (2008) Participation and the right to the highest attainable standard of health. Project Report. Human Rights Centre, Colchester, Essex. [Online] Available at: http://repository.essex.ac.uk/9714/ [Accessed: 3 October 2014].

Robson, C. (2011) *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* (3rd Ed.) Oxford, UK: Blackwell Publishers Ltd.

Sachikonye, T. (2010). African Feminism Driven by African Women. *NGO Pulse*. [Online] Available at: http://www.ngopulse.org/article/african-feminism-driven-african-women [Accessed: 14 September 2014].

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*. **22**(2004): 63-75.

Salas, M.A., Tillman, H.J., McKee, N. & Shahzadi, N., in association with UNICEF. (2007) *Visualisation in Participatory Programmes: How to Facilitate and Visualise Participatory Group Processes.* SouthBound: Penang [Online] Available at: http://www.southbound.com.my/vipp/index.htm [Accessed 10 October 2014].

Status of Women Canada (1996). *Working Document. Gender-Based Analysis: A Guide for Policy-making*. Status of Women Canada: Ottawa, Ontario.

Training and Research Support Centre (TARSC) (2006). Organising People's Power for Health. Harare: Training and Research Support Centre.

Training and Research Support Centre (TARSC) (2011). Supporting the role of Health Centre Committees: A Training Manual. Pilot Edition [Online] Available at: http://www.tarsc.org/publications/documents/HCC%20manual%20FINALAugust%202011.pdf [Accessed 2 September 2014].

Ulin, P. R., Robinson, E. T. and Tolley, E.E. (2005). *Qualitative Research Methods in Public Health: A Field Guide for Applied Research*. San Francisco, CA: Jossey-Bass.

United Nations General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III) [Online] Available at: http://www.refworld.org/docid/3ae6b3712c.html [Accessed 15 October 2014].

UNICEF Bangladesh. (1993). *Visualisation in Participatory Programmes: A Manual for Facilitators and Trainers Involved in Participatory Group Events*. New York: Programme Communication and Information Section, UNICEF Bangladesh

WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948.

Part B: Literature Review

A review of key literature related to the right to health and gender was undertaken between March and December 2014. This section critically reviews key themes identified in the literature relating to the right to health and gender, sexual reproductive health rights as a tracer of gender-related access, the role of gender and community participation in facilitating the right to health, and gender and power relations in Health Committees. The conceptual framework to be used in the research is presented, gaps in the literature are identified and research questions are set out.

Bibliographic databases including PubMed, Science Direct and EBSCO Host were searched along with relevant grey literature. Keywords used for the search included gender and human rights, gender, health and human rights, gender sensitive approaches to health, gender and community participation, power dynamics of Health Committees. English language literature published since 2003 and key texts before this period are included in the review.

The Right to Health

Human rights and the provision of health can be thought to be inextricably linked. Human rights are those stipulations ensuring that one can live with respect, dignity, autonomy and agency to demand basic needs and have protection from obstacles which may hinder these conditions (World Health Organisation, 2013). The ICESCR (1966) Article 12 defines the right to health as the right to the highest attainable standard of health. This legally binding document, in States where it has been ratified, has been further elaborated upon in General Comment 14 on the right to health (UN, 2000) and includes recognition of the indivisibility of health and human rights as fundamental for the exercise of all human rights (UN, 2000). This can be understood in that good health means physical, mental and emotional capacity to participate and contribute to social, economic and political systems, allowing a productive life. As civil and socio-economic rights go hand in hand, this constitution of health as a right makes health care amenable to a rights-based approach (London, 2008). A human rights lens justifies the need for accountability for appraising such rights, thereby

empowerment can be sought to procure agency of the physically, socially or economically disadvantaged (London, 2008).

The right to health, as elaborated on in General Comment 14 (UN, 2000), sets out guidance on state parties' obligations to protect, respect and fulfil the right to health. It involves the actions taken by the state to ensure the entitlement of all citizens to access to equal and quality health information, services and facilities in order to fully enjoy continued health and well-being. This is conceptualised within the principles of availability, accessibility, acceptability and quality of health care services and the determinants of health (UN, 2000). Availability speaks to health care goods, services and programmes being available in sufficient supply to suit the demand of respective populations seeking health care. The types and forms of these goods, services and programmes will depend on multiple factors and determinants around the country's current developmental stage. Accessibility involves health care goods, services and programmes being accessible to all, in terms of physical accessibility, affordability, non-discrimination between providers and recipients and information imparted to or available to be sought by the public. Acceptability requires all health care goods, services and programmes to be ethically sound and culturally appropriate in their forms and application in that they respect confidentiality and aid improving the health of all who partake in them. Quality concerns the sufficient medical and scientific appropriateness of the goods, services, programmes, skills of personnel, sanitation, and so forth (UN, 2000).

In conjunction with the role of the state and other governing bodies, it has emerged that harmonising health and human rights could best be achieved through a rights-based approach, emphasising the dimensions of need and agency of all players in addressing inequality and promoting adequate responsiveness of the health system, as well as the awareness of the public in accessing these rights (Strecker, Stuttaford and London, 2014). South Africa has aligned itself with

strong dedication to championing and preserving human rights, exalted in its Constitution, rights-based approach to policy and development, and demonstrated by signing of international treaties promoting equality, including the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979), adding to the conceptualising of reproductive and health rights at the 1994 Cairo Conference on Population and Development and the 1995 Beijing Fourth World Conference on Women (Klugman, 2000, in Muller and MacGregor, 2013) as well as adopting the Millennium Development Goals (MDGs) in 2000 (Muller and MacGregor, 2013).

As a member state of the African Union, South Africa's commitments to promoting women's health also stem from the Protocol to the African Charter on human and People's Rights on the Rights of Women in Africa (1995), which has designations, among others, for the elimination of discrimination against women, the right to life, health and reproductive rights, the right to education, and a clause dedicated to the right of women to participate in political and decision-making processes. The African Commission on Human and Peoples' Rights complemented this binary framework with Resolution 275 (2014) which affirms that member states will actively resolve to curb violence and abuse targeting persons on the basis of their real or perceived sexual orientation or gender identity, and calls for protection of the rights of sexual minorities. This was a landmark development given the legislative response and prevalent criminalisation of SOGI in the broader African continent (Amnesty International, 2013). South Africa has been a forerunner in this regard, with the Equality clause (section 9) of the Constitution (1996) which stipulates that all people are equal before the law and that equality constitutes full enjoyment of all rights and freedoms, and protection thereof. No person or the state may directly or indirectly discriminate against any person on several grounds including gender and sex – listed separately – and specifically includes "sexual orientation" amongst others such as race, age, colour, and ethic or social origin. Emphasis is placed on guarding against unfair discrimination, allowing fair discrimination which may apply in cases such as the African Charter's call for affirmative action

processes in advancing the participation of women in governance, for example. Measures must be taken to protect and advance those who are unfairly discriminated against and national legislation must be implemented to prevent all forms of unfair discrimination.

Gender

Gender is defined by WHO as "the socially constructed roles, behaviours and activities, and attributes that a given society considers appropriate for men and women" (WHO, 2014). However Johnson and Repta (2012) articulate how gender as well as one's sex or biological characteristics are fluid and temporal, hence binary approaches to gender may not be sufficient. There is an important dimension of how one feels about the sex they were born with and the gender one feels aligned with, leading to terms such as cisgender, or those for whom their sex at birth and gender identity match, and transgender, those whose sex at birth does not match their gender identity (United Nations Development Programme [UNDP], 2013). Added to these are many other gender identities along a transgender spectrum, including those who identify as non-gendered, a third gender, or gender queer (someone whose gender expression is more fluid). All genders may or may not fall under the gender variant spectrum, as people who express their gender differently from social stereotypes (UNDP, 2013). The nomenclature is important as gender-sensitive health services mean recognising the needs and complexities of the genders beyond merely reproductive functions (Donner, 2005). It is important to take gender into consideration because the patriarchal dynasty of gender-based inequality has meant differences in access, treatment and power, with disproportionate emphases placed on some health interests over others, which has ripple effects for the community at large. Bridging the gap in knowledge around women's health issues does not mean the exclusion of men, but attempting to match and improve the body of knowledge and best practice for all genders (Donner, 2005).

Gender and the Right to Health

A fundamental step to fully realising the right to health in populations is shining a light on gender and the right to health (UN, 2000). Gender in development and public health has evolved to present a dynamic and fluid picture of intersecting paradigms. The binary concept of gender has historically been at the forefront and dealt separately from gender identity and sexual orientation in health and human rights legislation. Article 12 of The Convention for the Elimination on all forms of Discrimination Against Women (CEDAW) (1981) affirms that ratifying countries will eliminate discrimination against women in the health care field and ensure equality of men and women to secure access to health services. The Article also prioritises appropriate and if possible free services for pregnancy, post-natal and nutrition services for women. Article 7 also provides for women being on equal terms with men in participation in political life by being eligible to hold public office and participate in developing and implementing government policy at all levels. This lends itself to community participation in health governance structures such as clinic health committees. The binaristic lens of CEDAW has been followed by the United Nations Human Rights Council Resolution 17/19 (2011), which raised concerns over discrimination and violence perpetrated against individuals on the basis of their sexual orientation or gender identity, and promoted the investigation of discriminatory laws and practices globally. In attempting to broaden "gender" beyond the binaristic lens, intersectionality can be applied so that the intersections of women, gender minorities and sexual minorities could be investigated together in terms of their linkages in public health interventions and experiences in community participation. Intersectionality asserts that one identity alone such as gender or sexuality does not adequately assess the unequal outcomes without the intersection of the other identity or identities (Bowleg, 2012).

Women and Sexual Orientation and Gender Identity (SOGI)

Public health studies centred on gender have traditionally shown the marginalisation of women and girls in societies continue to inhibit access to information and services, acceptable care and increase

their vulnerability to discrimination and abuse. Amnesty International (2017) reported on the many barriers to safe abortions in South Africa including unequal infrastructure, poor access to information or being denied care. Delayed care, inadequate assessments and verbal and physical abuse contribute to high maternal mortality rates in South Africa (Human Rights Watch, 2011), with violence and sexual abuse being perpetrated occurring against mothers with disabilities in Bangladesh (Naved, Blum, Chowdhury, Khan, Bilki & Koblinsky, 2012). Globally, female adolescents are at high risk of sexual reproductive health problems and do not receive quality of care (Chandra-Mouli, Armstrong, Amin & Ferguson, 2015).

In recent decades, broadening the understanding of the gender spectrum and sexuality as encapsulated by SOGI has found a hard-won place among gender studies. This is amidst many challenges for full recognition of sexual orientation as an indicator of sexuality and sexual health rights and having direct links to vulnerability of sexual violence (Saiz, 2004). The WHO's 2015 publication on *Sexual Health, Human Rights and the Law* furthers this by acknowledging that sexual health includes diverse expressions and that recognition of these contributes to health and well-being. The report covers the vulnerabilities and discrimination associated with sexual orientation and gender identity as social determinants of health, including transgender and gender variant people. In practice many challenges persist with sexual minorities facing stigma and homophobic assault in clinical settings (Lane, Mogale, Struthers, McIntyre and Kegeles, 2012), adopting strategies of discrete bisexuality with compounded vulnerability to poor access to HIV treatment and care (Epprecht, 2012), and a lack of support for sexual minorities and sensitivity training (Rispel and Metcalf, 2009). In public health research prompting response, much of the language around SOGI in public health is still contested, as the terms "men who have sex with men" and "women who have sex with women" have been promulgated to detach identity from health risks whilst it is also contended that this undermines self-determined sexual identities such as gay or lesbian (Young and Meyer, 2011).

Gender and the Right to Health Legislation

General Comment 14 (UN, 2000) provides consideration specific to gender and the right to health, particularly concerning women's health and maternal health. It attempts to include a gender perspective-based approach by calling for improved data showing discrepancies according to gender to address inequalities, and for nations to make particular efforts to promote women's health programmes and access to care. As reported in Snowdon (2013), bias and social exclusion and discrimination leads to delayed or avoided health care access particularly by transgender individuals, some of whom hold fears of being supplied with substandard care or simply being turned away. In response, health providers are encouraged to cultivate non-discriminatory and welcoming health care environments within facilities and bolstered by non-judgemental provider-patient relationships. Such guidelines, even when additionally steeped in constitutional legislation, may not always be followed through without the supporting social mores perpetuating their adherence. It has been suggested that a shift be made from health professionals being the sole upholders of health rights to a more collaborative approach whereby both health professional and health care users champion these rights and invest in local health objectives (London, 2008). Non-discriminatory policies also have credence in being applied in health workforces and in other human resource matters as Newman (2014) outlines a need for research on gender-specific tendencies and interactions within the health workforce.

Gender-Sensitive Approaches and Gender-Based Analysis

Gender-sensitive approaches include tools such as Gender-based analysis (GBA) in health, which allows for a more comprehensive understanding of how the experiences of the genders differ and converge, considering health status, health needs and use of health care (Donner, 2005). GBA comprises ascertaining relevant questions around how policies, programmes and other activities have an impact on gender and all circumstances surrounding them in order to produce appropriate and inclusive responses to these matters (Health Canada, in Donner, 2005). Gender is relevant in

health service provision as services may be given or addressed in different ways according to gender values and norms which have various effects on the likelihood of exposure to health risks (Mboi, 2014). McNutt (2010) argued that gender mainstreaming, or the approach to strategising for gender equality through integrating gender perspectives across all activities such as policy development, research and programmes (UN, 2002), has been met with challenges in implementation, largely due to failure to sufficiently reform existing policies and procedures to introduce substantive gender mainstreaming efforts. Its success has depended on existing political will and commitment to reducing gender inequality, as its tools of gender-based analysis involves the hefty undertaking of identifying and redefining issues in order to completely overhaul legislation (Status of Women Canada, 1998)

Gender and Sexual Reproductive Health Rights

A wealth of literature appears to use "gender" to denote "women's health" and the core topics under these headings are predominantly around maternal and infant health, followed by sexual and reproductive health (SRH). This presents a narrow view of a multifaceted domain of healthcare in populations. General Comment 14 too appears to emphasise reproductive and maternal health as core issues of women's health. Yamin (1997) suggests that human rights norms can produce a framework for understanding women's health that is beyond biological preoccupations with women as vessels for reproduction. This emphasises a re-framing of human rights foci to mean empowerment of all individuals to exercise their rights over their physical, social and emotional selves, not due to their assigned gender or social roles but simply in light of their inherent human right to live in dignity and participate in social, economic and political constructions that shape their quality of life. This appears to put forward a gender-neutral conceptualisation of health and human rights whilst still applying gender-sensitive principles in health service provision. As illustrated by the reproductive health approach, a woman's reproductive health is aided by the level of agency she has to make decisions about her reproductive health, which is further benefited by advancements in

her socio-economic status (Indian Statistical Institute, 2014; Wang and Pillai, 2001). It follows that adequate sexual and reproductive health includes the total well-being of the individual in relation to their social, physical, economic and political aspects of life. Wang and Pillai (2001) outlined Sen's (1994) listing of instrumental shortcomings of social policies regarding the disproportionate role of women in reproduction and associated responsibilities.

Despite the seeming limitation of SRH being most prevalent in gender and health literature, it follows in this work as the South African Department of Health also include gender-based violence in its all-encompassing definition of sexual reproductive health rights (Muller and MacGregor, 2013). This hints at a prelude to the possibility of gender-sensitive health services and practitioners. South Africa has achieved much as a front runner in protecting SRH rights in the eyes of the law and implementing many SRH guidelines such as widespread availability to contraception, family planning services, termination of pregnancies and HIV counselling and care (Ramkissoon et al, 2010). Regarding the strides made in women's SRH following the new democracy in South Africa, Cooper et al (2004) found improved contraception policy but limited contraceptive method choices; the provision for free maternal care had seen a drop in maternal mortality but this was limited to urban areas and was threatened by the rising HIV/AIDs pandemic; the introduction of the Termination of Pregnancy Act 1996 decreased abortion-related morbidity by almost half, although a shortage of trained and willing health professionals remains a challenge; cervical cancer as the most common cancer in black women has been prioritised with plans for free national roll-outs, however implementation at district level remains to be integrated; and although gender-based violence statistics are perennially unreliable, reporting and protection orders have increased since the highly revered The Domestic Violence Act (1998) along with various challenges such as poor coordination and training in service delivery to survivors of sexual assault.

Despite this, South Africa is burdened by alarmingly high rates of women bearing the brunt of inequality, poverty and high risk of HIV/AIDS, with poor access to health services, as well as having the highest incidence of gender-based violence globally (Müller and MacGregor, 2013). Osman (2011) attributes some of the failings of health care service delivery to a misalignment of SRH and HIV prevention and services, in that sexually-transmitted infections (STI) other than HIV may be misdiagnosed or overshadowed by HIV prevention. Although the prioritisation of HIV control and treatment measures are universally sanctioned, as by-product has been compromised treatment of STIs, with patients receiving inadequate care or care only once highly symptomatic (Osman, 2011). Furthermore, a 2011 report from the South African Department of Health on SRHR lists other general barriers to the realisation of SRHR on the ground as being gender inequality and the prejudices of stigma, poor management and stewardship of health facilities and a need for improved research to inform planning and monitoring of SRH services.

Community Participation and Gender and Power Relations

One of the most important elements of a decentralised health system is the implementation of primary health care, outpatient mobility and community participation in its many forms, including Health Committees in South Africa's district health system (Haricharan, 2012). Health Committees are connected to a specific health facility and may be comprised of medically trained personnel or volunteers from the community of no specific occupation and must include a local government ward councillor and the head of the particular medical facility (Haricharan, 2012). Müller (2013) clarifies how Health Committees can serve as vital conduits for improved education of patients, feedback to staff and more effective service provision. Partnerships between community nurses and transgender and gender non-conforming individuals are imperative to foster caring environments responsive to health needs (Thornhill and Klein, 2010). Social mobilisation via community participation reads as an intuitive vehicle for the human rights approach to health, however this does not deem it infallible. Study of civil society efforts such as Health Committees lacks a focus on the

role of gender and gendered power dynamics within such structures, as a function of the committees themselves (how they are characterised) and in terms of the outcomes they deliver.

Decentralisation of health care services planning proves efficient with the caveat of power imbalances found in partnerships between central government and district facilities, local NGOs and by extension, community participation structures. The conveyance of greater responsibility and authority is often not backed up by finances, resources or staff to fulfill the implicit mandate to compensate for excess need (Petchesky, 2003). Alongside unchallenged gender norms and power dynamics in communities, this is disruptive for women's health programmes. A feminist critique opens up avenues into issues of power, power dynamics in health systems and the part of gender in navigating these structures, at all levels. Nevertheless, NGOs and community participated structures have a crucial role to play in engendering innovation, advocating for health rights and acting as catalysts for community participation in realising the right to health (Haslegrave, 2014).

The alliance of human rights and development has given way for community participation to be seen as a fundamental right of citizenship (McEwan, 2005). Citizenship, a widely contested term, is fundamentally concerned with the relationship between individuals and their community, and the individual and the state. This includes certain levels of status, responsibilities, and impacts on social, civil and political rights (Dwyer, 2000). Participation as a form of active citizenship consists of encouraging public involvement in decision making processes around service provision, in tandem with expert driven processes. Health committees contribute to their wider communities by taking up the task of enacting the right to health, information and others in pursuit of inclusive citizenship to address inequality in health service access and delivery (McEwan, 2005).

Health Committees as representatives for the community come with a unique mix of prejudices and tendencies of the actors. Hierarchies may form or be enforced, possibly following gender norms as extensions of the gendered privilege at all levels of the health system, often at the expense of women and disadvantaged populations. As a possible remedy to counteract such structures, specific gender management programmes can partner with local NGOs or health facilities to implement sustainable solutions to increase participation of women and disadvantaged groups, as seen in Nepal (Rottach, 2013).

General Comment 14 suggests a gender-based approach to policy and the provision of health services but does not extend to issues of governance within health bodies themselves. This could infer agency on the part of states to delineate their own configuration of gender mainstreaming within health care facilities and human resource policies. Human resources, including dedicated and equitable health care committees, play an integral part in health systems strengthening, ensuring quality health services and allowing positive health outcomes (UN, 2000). The health care workforce tends to be predominantly composed of female staff and volunteers, yet more often than not in low ranking positions or with limited decision-making power (Sen, Ostlin and George, 2007). This is applicable to Health Committees where gender and power dynamics are liable to form hierarchies that undermine the agency of committee members. This speaks to the social structures of gender roles within Robert Connell's 1987 theory of gender and power (Wingwood and DiClemente, 2000), particularly the division of power, the division of labour and the structure of cathexis at institutional level. Control mechanisms such as abusive or corrupt actors in institutions, unequal access to opportunities and even negative media input can reinforce the status quo of power imbalances in the very structures positioned to address inequality (Wingwood and DiClemente, 2000).

Conclusion

Given the backdrop of a renowned constitution and the complete health system transformation which has occurred (and is still under way) in South Africa, receiving the baton of monitoring and evaluating such changes and progress appears most pertinent. Assessing impact need not mean calculating and comparing health outcomes, but evaluating the specific contexts and functioning of agents involved in bringing about desired objectives of equal access to gender-sensitive services. As with many sectors in the country, the process of transition is simpler, apparent and faster in some tasks, whilst some changes are more complex, nuanced and slower to emerge. Using a gender-based analysis of functioning Health Committees could unveil the stumbling blocks in translating policy to practice. Such investigation is crucial, as despite positive health outcomes engendered from post-apartheid policies, gender-based discrimination is the invisible threat and stranglehold, which continues to hamper significant progress in dividends unknown.

Exploring matters so entwined as gender discrimination in both health services provided and amongst health providers themselves leads to questions about the application of gender and gender and power relations in health spaces. What is the role of gendered power relations in Health Committees in the Western Cape? What is the perception of gender equality of Health Committee members in the Western Cape? How does gender impact on the role and functions of the Health Committees (as stated by the Health Committees)? How do gendered power relations influence the health issues in which Health Committees engage? Interviews with key informants and Health Committee members could aid in understanding the extent of progress or problems perceived around provision of gender sensitive services and power dynamics in efforts to realise them and whether the root of such problems lie in a lack of training or some other more elusive factors. It could then be determined how Health Committees are meeting their responsibilities toward non-discrimination in both the provision of care and in the management of health care provision itself, and the appropriate routes to tackling such discrepancies.

References

African Commission in Human and People's Rights (1995). Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

African Commission in Human and People's Rights (2014). Resolution 275: Protection against Violence and other Human Rights Violations against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity.

Amnesty International (2013). *Making Love a Crime: Criminalisation of Same-Sex Conduct in Sub-Saharan Africa*. London: Amnesty International Publications

Amnesty International (2017). *Barriers to Safe and Legal Abortion in South Africa*. London: Amnesty International Publications.

Bowleg, L. (2012). The problem with the phrase *Women and Minorities*: Intersectionality – an important theoretical framework for public health. *American Journal of Public Health* **102**(7) pp. 1267-1273.

Chandra-Mouli, V., Armstrong, A., Amin, A. and Ferguson, J. (2015). A pressing need to respond to the needs and sexual and reproductive health problems of adolescent girls living with HIV in low- and middle-income countries *Journal of the International AIDS Society* **18**(Suppl. 5) pp. 20297

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries, J., Cullingworth, L. and Hoffman, M. (2004) Ten years of Democracy in South Africa: Documenting Transformation in Reproductive health policy and status. *Reproductive Health Matters* **12**(24) pp.70-85.

Department of Health (2006). *Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa*. Department of Health: Pretoria, South Africa.

Donner, L. (2005). Including Gender in Health Planning: A Guide for Regional Health Authorities. Winnipeg, MB: Prairie Women's Health Centre of Excellence. 47p [Online] Available from: http://www.pwhce.ca/gba.htm [Accessed: 5 July 2014].

Dwyer, P. (2000). *Welfare Rights and Responsibilities: Contesting Social Citizenship*. Bristol: Policy Press.

Epprecht, M. (2012). Sexual minorities, human rights and public health strategies in Africa *African Affairs* **111**(443) pp. 223-243.

Haricharan H. (2012). Extending Participation: Challenges to Health Committees as meaningful structures for community participation. Human Rights Division, School of Public Health, University of Cape Town.

Haslegrave, M. (2014). The role of NGOs in promoting a gender approach to health care. [Online] Un.org. Available at: http://www.un.org/womenwatch/daw/csw/role_ngo.htm [Accessed: 15 June 2014].

Hennink, M., Hutter, I., and Bailey, A. (2011). *Qualitative Research Methods*. London: Sage Publications.

Human Rights Watch (2011). South Africa: Failing maternity care Abuse, Poor Accountability causes needless Death and Suffering. [Online] Available at: https://www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care [Accessed: 24 June 2017].

Indian Statistical Institute. (2014). *Need for Gender Sensitive Approaches for Improving Women's Reproductive Healthcare Services.* [Online] Available at: http://gme-cehat.org/Papers/Veiw_Paper.aspx?acat=Institutional%20Papers&aid=63&dbFrom=1 [Accessed: 7 June 2014].

Jacobs, B. (2013). Unbounded by theory and naming: Survival Feminism and the women of South African Victoria Mxenge Housing and Development Association. *Berkeley Journal of Gender, Law & Justice*. **26**(1) pp.19-77.

Jefferies, B. (2011). Critical Realism – an empirical realist critique. Working paper 11-03. Manchester Metropolitan University Business School.

Johnson, J., and Repta, R. (2012). Sex and gender: Beyond the binaries (pp. 17-39). In J. Oliffe, & L. Greaves (Eds.) *Designing and Conducting Gender, Sex, & Health Research.* Thousand Oaks, CA: SAGE Publications, Inc.

Johnson, R. B. and Onwuegbuzie, A.J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher* **33**(7) pp.14-26.

Lane, T. Mogale, T., Struthers, H., McIntyre, J. and Kegeles, S.M. (2008). "They see you as a different thing": The experiences of men who has sex with men with health care workers in South African Township Communities *Sexually Transmitted Infections* **84**(6) pp. 430-433.

London L. (2008). What is a human-rights based approach to health and does it matter? *Health and Human Rights* 10(1): 65-80. [Online] Available at: http://www.hhrjournal.org/index.php/hhr/article/view/25/108. [Accessed: 20 Mar 2014].

Mboi, N. (2014). Why does Gender Equality Matter in Public Health? The Global Fund. [Online] Available at: http://www.theglobalfund.org/en/blog/2014-03-07_Why_Does_Gender_Equality_Matter_in_Public_Health/ [Accessed: 17 June 2014].

McNutt, K. (2010) An Integrated Approach to Gender Equality: From Gender-Based Analysis to Gender Mainstreaming. Johnson-Shoyama Graduate School of Public Policy, University of Saskatchewan, Canada. February (2) pp.1-13.

Müller, A. (2013). Community participation in health. *Nursing Update*. May 2013, pp 26-29.

Müller, A. and MacGregor, H. (2013). Sexual and reproductive health rights of women living with HIV in South Africa. IDS Evidence Report 3. Institute of Development Studies Report. [Online] Available at: https://www.ids.ac.uk/publication/sexual-and-reproductive-health-rights-of-women-living-with-hiv-in-south-africa [Accessed: 19 May 2014].

Naved, R.T., Blum, L.S., Chowdhury, S., Khan, R,. Bilkis, S. and Koblinsky, M. (2012). Violence against women with chronic maternal disabilities in rural Bangladesh. *Journal of Health, Population and Nutrition* **30**(2) pp.181-192.

Newman, C. (2014). Time to address gender discrimination and inequality in the health workforce. *Human Resources for Health*, 12(25) 1-11. [Online] Available at: http://www.human-resources-health.com/content/12/1/25 [Accessed: 14 June 2014].

Osman, S. (2011). Women's Reproductive Health in South Africa – A Paradox. http://www.ngopulse.org/blogs/women-s-reproductive-health-south-africa-paradox

Petchesky, R. (2003). *Global Prescriptions: Gendering Health and Human Rights.* London: Zed Books.

Ramkissoon, A., Searle, C., Burns, C. and Beksinska, M. (2010). Sexual reproductive health and rights. *South African Health Review* 33-48. [Online]. Available at: http://www.popline.org/node/229526 [Accessed: 1 July 2014].

Republic of South Africa, Department of Health. (2011). Sexual and Reproductive Health Rights: Fulfilling our Commitments 2011-2021 and Beyond.

Rispel, L.C. and Metcalf, C.A. (2009) Breaking the silence: South African HIV policies and the needs of men who have sex with men, *Reproductive Health Matters* **17**(33) pp. 133-142.

Robson, C. (2011) *Real World Research: A Resource for Social Scientists and Practitioner-Researchers 3rd Ed* Oxford, UK: Blackwell Publishers Ltd

Rottach, E. (2013). Policy Brief: Promoting Gender Equality and Social Inclusion in Local Health Governance in Nepal. Washington, DC: Health Policy Project http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=199

Sachikonye, T. (2010). African Feminism Driven by African Women. NGO Pulse. [Online] Available at: http://www.ngopulse.org/article/african-feminism-driven-african-women [Accessed: 14 September 2014).

Sen, G., Ostlin, P. and George, A. (2007). Unequal, unfair, ineffective and inefficient. Gender inequity in health: why it exists and how we can change it. WHO Commission on Social Determinants of Health. [Online] Available at: http://www.who.int/social_determinants/publications/womenandgender/en/ [Accessed 7 June 2014].

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information.* **22**(2004) pp.63-75.

Snowdon, S. (2013). Equal and respectful care for LGBT patients. The importance of providing an inclusive environment cannot be underestimated. *Healthcare Executive* **28**(6) pp.52-55.

Status of Women Canada. (1998). Gender-Based Analysis: A Guide for Policy Making [Online] Available at: http://www.pacificwater.org/userfiles/file/IWRM/Toolboxes/gender/gender_based_analysis.pdf [Accessed 10 July 2014].

Strecker, M., Stuttaford, M. and London, L. (2014). Health rights pamphlets: critical literacy and inclusive citizenship, South Africa. *Health Promotion International* **29**(2) pp.339-348.

Thornhill, L. and Klein, P. (2010). Creating environments of care with transgender communities. *Journal of the Association of Nurses in AIDS Care*, 21(3): 230-239.

Ulin, P. R., Robinson, E. T. and Tolley, E.E. (2005) *Qualitative Research Methods in Public Health: A Field Guide for Applied Research*. San Francisco, CA: Jossey-Bass.

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: http://www.refworld.org/docid/4538838d0.html [Accessed 14 May 2014].

UNICEF Bangladesh. (1993). Visualisation in Participatory Programmes: A manual for facilitators and trainers involved in participatory group events. New York: Programme Communication and Information Section, UNICEF Bangladesh

United Nations Development Programme. (2013). Discussion Paper. Transgender Health and Human Rights. UNDP HIV Health and Development Group, bureau for Development Policy, New York, USA

United Nations Office of the Special Advisor on Gender Issues and the Advancement of Women. (2002). Gender Mainstreaming: An Overview. New York

University College of London. (2010). Gender Analysis of the Kyrgyz-Swiss-Swedish Health Project (KSSHP) Phase V. Development Planning Unit. http://www.swiss-cooperation.admin.ch/centralasia/ressources/resource_en_197273.pdf

Wang, G. and Pillai, V. (2001). Women's reproductive health: a gender-sensitive human rights approach. *Acta Sociologica*, **44**(3) pp.231-242.

WHO. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June 1946, and entered into force on 7 April 1948. [Online] Available at:
http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/
http://www.who.int/about/definition/en/print.html
http://www.who.int/trade/glossary/story046/en/ [Accessed: 15 April 2014].

WHO (2013). The Right to Health Fact Sheet. [Online] Available at:
http://www.who.int/mediacentre/factsheets/fs323/en/ [Accessed: 15 April 2014].

Wingood, G. and DiClemente, R. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior* **27**(5) pp.539-565.

Yamin, A. (1997). Transformative combinations: women's health and human rights. *Journal of the American Medical Women's Association* **52** pp.169-173.

Young, R.M. and Meyer, I.H. (2005). The trouble with "MSM" and "WSW": Erasure of the sexual-minority person in public health discourse *American Journal of Public Health* **95**(7) pp. 1144-1149.

Part C: Journal Manuscript

Gender, Participation and the Right to Health: Health Committees in Cape Town, South Africa

Janet Austin

University of Cape Town

South Africa

Keywords: community participation; gendered power relations, health committee; health and human rights; South Africa

Key messages:

- Limited operationalisation of gender equality and health legislation inhibits enactment by health committees as participatory bodies.

- Health committees are not trained or supported to respond to the impetus of gender and health in their communities.

- Normative power dynamics inhibit the accountability of health committees to be representative of their communities.

Word count: 6385

Abstract

Community participation is widely recognized as integral to health systems and the right to health. Health committees (HCs) exemplify participation and accountability structures, influenced by multiple social factors yet little research has investigated the impact of gendered power relations. Where services for marginalised groups including women's and sexual orientation and gender identity (SOGI) minorities' sexual and reproductive health are under-resourced, HCs need to holistically represent their communities and be empowered to advocate for improved access for marginalised groups as both committee and community members.

At the time of data collection, the Western Cape Province, South Africa, had no legislation delineating HC jurisdiction, save for a 2015 Draft Health Facility Boards and Committees Bill. A qualitative, exploratory study was undertaken to investigate the role of gendered power relations within HCs in the Province. Multiple methods, including eight meeting observations, one group discussion, and seventeen in-depth interviews, were used at three settings between March and December 2015. African Feminist Theory, Connell's 1987 understanding of gender and power, and McEwan’s perspective on citizenship and community participation were incorporated within a Gender-based analysis.

Findings showed that perceptions of gender equality and gender relations amongst HCs remained largely unacknowledged. Normative gender roles persisted, revealing a disconnect between gender equality legislation and practice. A disease model over social model influenced health priorities and despite claims of non-discrimination, no evidence of support for committee participants or service recipients of all SOGI was observed.

It can be concluded that participation on HCs is highly gender role normative. Accountability suffers in the absence of a mandate for implementing gender equality in health care. Weak linkages for upscaling health needs require significant monitoring. Gender-sensitivity and the impact on health needs to be formally addressed to ensure full enactment of the recently passed Western Cape Health Boards and Facilities Bill (2016).

(Words: 300)

Introduction

The development of the primary healthcare approach has been firmly entrenched in South Africa since the White Paper on the Transformation of the Health System passed in 1997 (Kautzky and Tollman, 2008). This approach provides for a decentralised, district-based health system, with community participatory structures as health service and governance bodies reflecting the values of equality and non-discrimination as found in the South African Constitution (Chapter 2, section 9). South Africa has a legacy of structures mobilised around health, with Health Committees (HCs) becoming statutory bodies with the National Health Act of 2003. The Act stipulates that HCs must consist of a health facility manager, a ward councillor as a local Department of Health representative and community members, who may represent community-based and non-governmental organisations (CBOs and NGOs). The functioning of the HCs is to be mandated through provincial legislation, which the Western Cape Province had not passed at the time of the research but began to circulate as a Draft Health Facility Boards and Committees Bill in 2015 (Draft Bill). HCs in South Africa and globally have established themselves as vehicles to the right to health (Loewenson et al. 2004; McCoy et al. 2012; Haricharan, 2013). The roles and duties of HCs include assisting health facility management to identify community priorities and approaches through which to address them, gathering feedback on such improvement measures, championing effective communication of communities through complaints and other mechanisms, monitoring and evaluating facility functioning through sporadic visits, encouraging volunteerism and building community support for facilities (Draft Bill, 2015).

The right to health as defined by General Comment 14 (UN, 2000) includes the promotion of gender and health, and calls for improved accountability and redress regarding gender inequality in health. Gender does not only encompass the social roles and behaviours attributed to cisgender (people whose gender is in accordance with their sex) men and women (UNDP, 2013) but the many

gender identities and minorities on the transgender spectrum (those whose gender identity differs from their gender assigned at birth). Women, and sexual and gender minorities (this term is used in favour of the acronym LGBTQIA+, due to its inclusion of all gender and sexual minorities, as well as people who engage in same-sex practices but do not necessarily identify as homosexual, e.g.: women who have sex with women (WSW)) are disproportionately at risk of mental and sexual health disparities due to discrimination and non-inclusive healthcare facilities and staff (Snowdon, 2013; Pega and Veale, 2015). The health and marginalisation of women and SOGI are routinely framed separately in global legislation, characterised by CEDAW (1979) and the UN rights Council Resolution 17/19 (2011), respectively. Applying an intersectional approach to health service access asserts that the marginalisation of one identity, for example gender, cannot be adequately explained without acknowledging another such as sexuality or race (Bowleg, 2012).

Since 1994, the transformation of SRH policy in South Africa saw gains but was hampered by stilted integration of services at district level and limited training (Cooper et al, 2004. The need for a gender sensitive approach to health arises from the recognition of the needs and difficulties faced by the genders beyond their reproductive abilities (Donner, 2005). This has implications for health service planning and training of health personnel, as health services can be impacted by the cultural beliefs and norms perpetuated by staff. Systematic gender discrimination and inequality within healthcare workforces also presents a challenge to health outcomes and suggests the need for gender-targeted governance and education (Newman, 2014).

As vehicles of community participation, HCs are uniquely placed to represent their communities and advance the health rights of all, regardless of their gender or sexual orientation. A rights based approach to health through participation means the emergence of HCs as campaigners of improved healthcare access through sufficient representation of diverse communities, accountability to uphold equality and non-discrimination and support advocacy to ensure availability, accessibility,

acceptability and quality of healthcare (Haricharan, 2012; UN, 2000). A major tension is that these community participation rights and implied responsibilities of HC members co-exist with challenges to the realisation of other basic precendent rights in order to implement the right to health, such as the right to education and the right to safety. This has parallels to the realisation of the right to access to information, and to protest, as discussed by Chamberlain (2016) around the issue of "enabling rights". Here it was identified how problematic implementation of legislation to enable these rights is counterproductive to actual manifestation of such rights; an example being the high proportion of denials of requests for information by civil society due to poor understanding of the Promotion of Access to Information Act 2 of 2000 by officials and disregard for access to information rights by ignoring such requests. For HCs tasked with improving access to the right to health, oversights in HC legislation such as the inability to fundraise perpetuates a dependence on local government and competing for other benefactors to sponsor their activities, which impedes the decentralised agency that community participation structures should have to mobilise resources to support health service delivery (Frumence et al, 2014).

Within the Act and national and international literature there is little explicit mention of gender power relations in HC functioning and how this impacts health care provision (Newman, 2014). While power and governance are recognized (Lehmann and Gilson, 2013; Maluka and Bukagile, 2016) the dimension of gender requires further exploration in light of the policy context set up to enhance gender equality in participatory environments (Cornwall, 2003; Newman, 2014). Perceptions of gender and gender equality among HC members need to be understood to ascertain the awareness of gender as a determinant of health and examining the influence of gender on functioning of HCs themselves could infer how gender and health is prioritised. Added to the realisations of accountability and representation, the question addressed in this paper is: What is the role of gendered power relations in health committees in the Western Cape?

Conceptual Framework

The meaning of gendered power relations in this study adopts Connell's 1987 relational theory of gender and power. This concerns the enduring structures of relationships between the genders, concerning the sexual divisions of power, labour, and cathexis. These social and institutional structures of gender role division are so entrenched as to perpetuate gender stereotypes despite progressive developments in extending gender equality at large. This is appropriate for a study concerning HCs as participatory structures tasked with upholding values of gender equality whilst competing with relational interpersonal, intrapersonal, institutional and social patterns of how gender is enacted (Connell, 2012). A related perspective is that of gendered participation as a construction of citizenship (McEwan, 2005). HCs are a vehicle for active citizenry in seeking the right to health yet can still be exclusionary when power is not addressed, leaving members such as women and sexual and gender minorities marginalised whilst “participating” (McEwan, 2005).

Exploring the role of gender in a health system in reform since South Africa's first democratically elected government amends itself to an African Feminist lens. Broadly, the aim is to distinguish the histories and experiences of women previously and currently disadvantaged and raise awareness of their plights against mainstream Western feminism which has been exclusionary of women of colour in its scope (Gouws, 1996; Goredema, 2010). The temporal dispositions shaped by political eras put forward by African feminism more accurately accounts for the situation and progress of community participation in South Africa. Gender-based analysis provides the basis for reviewing representation and decision-making (Donner, 2005) as found in health participation structures to highlight gender issues, with the aim of gender mainstreaming to transform gender relations and structures (McNutt, 2010).

Methodology

An exploratory interpretive study using an interpretative research design was conducted using multiple qualitative methods. These included meeting observations of eight HC meetings, one group discussion session using visualisations in participant programs (VIPP) methodology (UNICEF, 1993) (see Appendix D), and 17 in-depth interviews (see Table 1).

Table 1. Data Collection Methods

Method	Participants	Gender	Total
Meeting Observations	HC 1 (2 meetings) HC 2 (4 meetings) HC 3 (2 meetings)	10 Females 9 Females, 1 Male 6 Females, 2 Males	8 Meetings
Group Discussion (Diagramming and Visualisations)	All members of 1 HC	9 Females, 1 Male	1 Group
In-Depth Interviews	*Health Committee 1* 1 Sub-district Manager 3 HC members: o 2 retired nurses o 1 unemployed member *Health Committee 2* 1 Sub-district Manager 5 HC members: o 2 community workers o 2 unemployed members o 1 retired home-carer *Health Committee 3* 1 Sub-district Manager 1 Facility Nurse 5 HC members: o 1 local business owner o 1 tradesman o 1 unemployed member o 1 pensioner o 1 retired home-carer	Female 2 Females Female Male 2 Females 1 Female/1Male Female Female Female Female Male Male Female Female	17 Individuals

VIPP comprises a range of participatory group exercises during which responses to certain questions and activities are recorded on paper or items are marked with stickers to create a visual representation of the group's narrative on the topic being explored. Data was transcribed and analysed using thematic analysis.

Setting

Fieldwork was conducted with three HCs in the Cape Metro district of the Western Cape from March to December 2015. The HCs are situated in low income suburbs with many security and financial stability threats; respondents reported high levels of unemployment, substance abuse, teenage pregnancy and in some cases gangsterism, in their communities. HC members are often from challenging circumstances, being the sole breadwinners, retired, or reliant on welfare grants or partial pensions – as little as R600 ($46) per month. Precautions were taken to not impose time or resource costs upon HCs or otherwise burden the members. Vulnerable populations of HCs are overwhelmed by urgent health priorities and the recruitment as well as the researcher-respondent dynamic can be potentially problematic. One key informant per committee volunteered their HC for selection and thereafter provided access. All fieldwork logistics were settled at the discretion and convenience of the HC members.

Sample

The Cape Metro Health Forum executive committee provided access to the HCs. Sub-district managers volunteered their committees on the basis that they were adequately functioning and not already engaging in other research. As selection criteria, all HC members had to be at least 18 years old and have been members for at least one month.

Ethics

Ethical approval for the study was granted by the Human Research Ethics Council at the University of Cape Town (REC: REF.922.2014). Informed consent was collected for all participants and all

data anonymised. Interviews were conducted in the language of the respondent's choice (English or Afrikaans) and at a location at their convenience.

Reflexivity

The topic of gender and power as it relates to HCs was presented to me, which I thereafter designated as a probe into the subtle mechanisms behind the health indicators and outcomes more easily quantified. My interest in addressing gender and power dynamics as they relate to health made them no easier to unravel, and seeking answers from health personnel on these matters became quite an introspective and inadvertently demanding exercise for participants. I commenced with the understanding of gender containing a multitude of identities and had to navigate how it was understood by participants and if I would recognise it in their words. “Lack of knowledge” could also be translated as reluctance to divulge. I had to enter health participation spaces without imposing or embodying yet another concerning, subtle element to negotiate. Considering my position as a white, middle class female Master’s student, it was imperative to disrupt any automatic submissions to my privilege in the field. This would include ensuring that participants did not defer to me as an authority, seek my acknowledgement in meetings above all others or offer me “the best chair”, for example. It was important to explain that the research exercise was not putting them on trial or just for my own edification, and that their input would be meaningfully disseminated.

Challenges

Gender and gender power dynamics, community participation and the right to health can be difficult subjects to tackle in community settings. It was found that following little training or guidance around these issues, HC members appeared not to be familiar with the concepts involved or regularly given to consider them and so were not always able to expand on the topic in interviews. Basic terms such as gender and gender-sensitive health services were revisited at the start of discussions for clarification purposes and to encourage discussions to include them. However a clear distinction had to be made between establishing a common language for exploratory purposes

and subjecting participants to an impromptu training session. A significant feature of the findings was that respondent-led exploratory research meant that themes related to gender were sought out for elaboration, rather than gender explicitly. It was necessary to remain cognisant of possible skepticism towards research motivations and essential to not have members feel threatened in their positions or feel their work was devalued by questioning their operations and exposing gaps around gender-sensitivity. Upon finding that documents such as meeting minutes or HC records were inconsistent, absent, or unable to be shared, meetings became the first point of observation to aid development of interview schedules.

Findings and Discussion

Researching the question of the role of gendered power relations in health committees in the Western Cape yielded three main themes; the operationalisation of policy for gender and health equality, the mechanisms for representation and accountability, and the understandings of gender norms.

The Operationalisation of Policy for Gender and Health Equality

Health Committee legislation and Political Context

The HCs all shared a context of political uncertainty. The Draft Bill was in circulation during the fieldwork, which concerned many HCs due to its lacking recognition for existing committees in favour of inconclusive guidelines for establishing new ones by the provincial health director. In addition, HCs described ward councillor members of the committee as being seldom present or in regular contact with their fellow committee members:

> “They haven't really, sort of, been present, and so [The ward councillor] said no, it's not him, he was never on it but he'll make a note” [HC2CM3]
>
> “We got no money at all so most of the time we approach the ward councillors that never come back to you” [HC1CM2]

Committee members also expressed skepticism towards factions of HC members representing local political parties, questioning their motives and their reliability of delivering the input that HCs need.

> “We told him to come but he never...as far as I know he was once at our meeting... and that was more than a year ago. He never comes to the meeting... they only come now because it's voting [near election time]...” [HC1CM3]

Discussion of uncertainty around HC standing and legislation, political party interests and absence of ward councillor input featured prominently in all of the meetings observed. Having a participatory structure's stability and legitimacy under question may distract and threaten their capacity (Haricharan, 2012). Though there is an agreement that HCs will assist at clinics, facility managers often utilise committee members as support staff, where duties range from managing patient complaints to even sweeping floors.

Disease over Social Models

South African legislation around sexual and reproductive health policy frameworks (Department of Health, 2011) and newer policy for gender equality (Women Empowerment and Gender Equality Bill (WEGE), 2013) may be progressive, but also vulnerable to continuing South African health system challenges of slow practical realisation via restricted resources and authority of facility managers (South African Human Rights Commission, 2009) or barriers by way of conflicting

beliefs of healthcare staff (London, 2008), hindering action by HCs. The observation followed that neither clinics nor HCs appear to consider gender in the services they provide with no mandate to do so, outside of essentialist services such as maternal care. HC members reported shortage of staff when considering how responsive they feel facilities are to gender-based needs. Health services remain fairly gender-neutral, and gendered health concerns and gender equality are not observably on the health agenda.

As voices of the community, the HC is supposed to champion the health needs they encounter as well as ensure consideration for diverse health concerns (Department of Health, 2004). This includes the needs and health disadvantages faced by women due to gendered power relations, for example vulnerability to sexual and gender-based violence (Dunkle, et al. 2004), as well as the needs of gender minorities in the realms of sexual health, healthcare access, and increased mental health risks as a result of this social exclusion and stigma (Pega and Veale, 2015). The misconception and non-prioritisation of gender on the ground is not due to negligence but poor awareness through lacking training and directives, which follows through from the exclusion of gender minorities as a vulnerable group by the 2003 National Health Act (The Legal Resources Centre et al. 2016). In practice, committee members are mostly preoccupied with home-based care and similar community work. At the clinics, there are routine activities include providing soup and bread for those waiting in long queues, or members default to the health causes laid out on the Health Calendar provided by the Western Cape Department of Health:

> "...what I've done for the now is I've got them a health calendar. On this health calendar... there is every type of disease, illness, whatever for each month... and they can choose a project." [HC3KI1]

This has by and large come to be relied on by committee members who do not feel assured of how to arrange their own activities without clinic input, or particularly encouraged to do so:

> "I can remember last year we had a year planning for all the events at the clinic... it's like the input that you put in... they don't recognise it... I'm sorry to say it but it's my opinion... we have the health year plan calendar, and we work on that... like every event but we think "what are we gonna do?"" [HC2CM5]

HCs were observably guided to support a medical model of health. The calendar and clinic mandates ensure a wide range of health issues such as various cancers, tuberculosis, hypertension and other conditions are addressed in communities far more frequently than social aspects such as disability, sexuality or gender-based violence. Committee members are otherwise more involved in prevention activities, such as giving talks at the clinic, taking questions and doing home visits:

> "We're working in clinics like explaining to people, everything like they can go for antenatal or, you know, HIV testing and all these things. TB people also come there and, we're there to talk to the people and that is mostly what we do." [HC1CM2]

These issues discussed are indicative of the inter- and intra-structural arms of power dynamics affecting HCs, who are at the mercy of lacking human and other resources. The *ad hoc* guidance of HC activities is endemic to systems without operationalised plans for ensuring gender mainstreaming in healthcare provision. The women in the committees are predominantly involved in implementation rather than the design or decision making around services. Economically disadvantaged and female members are overlooked by more vocal members or those with a closer

proximity to resources or authority, and so remain disempowered in participatory structures (McEwan, 2005). Therefore the mere presence of female HC members does not guarantee gender-sensitivity, equal representation of gender health rights or even underline needs specific to women. There is also nothing in place to buoy members to actively champion women's and SOGI minorities' interests, if they are not ideally represented within the committee. Without this input, HCs remain reactionary in response to largely communicable diseases instead, as evidenced by the many activities around HIV/AIDS and TB. They become entrenched in responding to the symptoms of systemic racial, gender and economic oppression, without contributing to the transformative strategies to counteract them.

The Mechanisms for Representation and Accountability

Representation through Convenient Recruitment

Operational idiosyncrasies observed in HCs maintain a deficit in representation and accountability. The Draft Bill specified that the Provincial Health Minister must nominate HC members, but no requirement of diverse membership regarding race, gender, ability or other identifiers was mentioned. HCs are essentially self-regulating and see fair member turnover, due to the high cost and commitment level relative to many of the members' living situations. Many newcomers join in hopes of receiving some kind of formalised training or income and drop out when these do not materialise. HC skill and efficiency is therefore in constant flux.

The revolving membership of HCs troubled some members who felt that the HC selection and election processes were not being respected. Furthermore, some committees regularly recruit friends or family members at their convenience, who have no particular interest in health or committee activities:

> "I know her, the one who works in the kitchen. And I asked her when I saw her the first time [at the HC meeting], "What are you doing here?" So she told me "I was just told I must come to the meeting..."... it's like it doesn't interested her, but she's there." [HC2CM5]

There is no standardised induction process whereby members are instructed on basic orientation around the clinic, First Aid skills, ethics and other social issues relevant to their service, including gender-sensitivity. Difficulties in responding to and increasing representativeness on HCs was explained by a HC member:

> Interviewer: "And so has the group tried to recruit more men or people with disabilities or trans people?
> Respondent: "Yes, but no people is interested."
> Interviewer: "How does the committee try to bring in new members?
> Respondent: "Um we talk about it whenever we see people like...I usually talk whenever I've got a club[for senior women], like I say please join...and someone will say they're interested" [HC1CM2]

The inability of the HCs to engage specifically with gender also inadvertently means an inability to ensure that they act as representative vehicles to the right to health for communities marginalised by patriarchal gendered power relations, including SOGI minorities. Non-normative gender identities and sexual minorities are disproportionately affected by health problems such as depression, substance abuse and other illnesses concordant with stigma and discrimination (Logie, 2012; Pega and Veale, 2015; Muller and Hughes, 2016). This community cannot have its diverse and complex needs met by participatory structures that do not acknowledge and provide for them specifically. It is a result of dominant cisnormative health practices, resources and training which limit the health committees in this capacity without any intervention from health managers and supporting

legislation made practicable. Stigma against gender minorities is not dissolved by claims of acceptance by single HC members, but by continuous advocacy and education. These individuals may likely refrain from partaking in full access to acceptable and quality healthcare (Stevens, 2012), perpetuating low impact and real world reach in previously disadvantaged communities. Committees otherwise tend to have long term members who establish themselves in the community by getting involved in other programs or specific health initiatives. These members try to influence committees to put effort into their chosen interests:

> "But what I would like to see is... my HIV people also get involved... it's almost time for the HIV project on the 1st of December, so I want to ask them[the committee], 'What are we gonna do?" and "How are we gonna do it?" [HC2CM3]

Members such as these with vested health interests or attachments to more organised institutions may capitalise on participation structures to seek a wider platform to reach the community they serve. It serves as another example of the disease mind-set evident in all arenas of HC participation.

Limited Accountability Mechanisms

Accountability structures to monitor and scale up intervention were also found to be stunted in HCs and lacking in the Draft Bill of 2015. Both the task delegation of facility managers and the low responsiveness of ward councillors may speak to the perceived lower status of HCs. The lack of support to mainstream gender services as well as the power and status differentials among HC members, impedes multi-party accountability (Tandon, 2002). As potential gatekeepers to care, they are awarded a responsibility which they cannot always fulfil due to poor project management and low engagement with other health stakeholders. This results in false autonomy that does not translate to responsiveness, as committees do not have the skills or resources to develop their own programmes and activities independent of the clinic or health calendar. Another gap in the

committees' work process was any kind of documentation system for members to actively record and report updates and trends in their work, or a regular transference thereof to the clinic or ward councillor in the interest of audit trails and accountability. Lacking records mean not contributing to indicators that currently necessitate increased state investment in our current market economy and corporate governance replicated by the healthcare sector (Petchesky, 2003). Documentation of health cases seen by HC members could contribute to disaggregated health data and tallying equity targets (Gruskin and Ferguson, 2013), as another facet of effective accountability and gender mainstreaming of healthcare practice.

The Understanding of Gender Norms

Training around Gender and Health

Gender, a term widely conflated with "women's health" or "female empowerment" (Wieringa, 1998) was barely featured by committee members overall. Interviews and observations showed that the notion of gender, its implications in health, and gender equality, are not well understood by the HCs and therefore not explicitly prioritised. When asked directly about any training on gender and health issues specific to different genders that might have been offered to HC members, the response varied from partial recognition to decisively negative or complete evasion. In response to the question regarding whether or not the HC had had any kind of training about differences experienced by women, men and SOGI minorities in health, one respondent emphasised self-reliance:

> "Nothing ...It's there where you have to learn yourself [sic], or read the newspaper or watch on TV, etc. You have to learn [sic] yourself to know that, the difference from this sickness and that sickness." [HC1CM3]

One respondent emphasised that their gender and health knowledge was relative to sex-specific diseases only, reflecting the disease focus of HCs over their standing as an inclusive accountability structure:

> "Yes, I think so, because you know sometimes they come they ask about prostate cancer, they ask about cervical cancer, all those things, and you can at least explain to them what it is and how did it start and so, I mean, a lot of them have got knowledge of all these things like TB, Aids and that." [HC1CM2]

However other respondents readily listed their varying training accomplishments but left the exploration of gender and health awareness to be undetermined, as exemplified here:

> "We had a lot, Metro arranged such a lot of workshops that we attended. Day Hospital gave them, they have certificates from the Minister of Health,…we had paediatric First-Aid training, Red Cross we had workshops, disaster management training... we had a lot of training." [HC3CM2]

This array of medical training received by HCs emphasises their role in augmenting medical services as opposed to their crucial capacity for representation. When pressed further about training on gender and health topics specifically, the respondent referred to their willingness to attend all of the aforementioned trainings despite travel costs. The issue of access, capacity building opportunities and role-player investment was observed to necessarily precede concerns around engagement with progressive policy and quality of training content.

Gender-neutral Approaches to Service

Health issues in meetings were predominantly observed to be linked to event planning and reports, keeping to a generalised genderless medium, and thereby "invisible" in favour of common basic needs such as supplying food for clinic attendees spending several hours at the clinic:

> HC member (HCM) 1 (Facility nurse): "Is there anything you would like to do for World Aids Day? What would the HC like to contribute?"
>
> HCM 2: "What did we do last year?"
> HCM 3: "Last year we gave packets with condoms... We must introduce ourselves and give a talk about AIDS"
> HCM 4: "Okay. Is the clinic gonna provide something for the people to eat?" [HC1]

This paternalistic approach to health matters may be explained by pressing contextual needs due impoverished committee contexts, as well as the social conditioning of minimising gender disparities, through what Goredema (1993) describes as an expected attitude of selflessness to be performed by African women. This also follows on from relational theories of gender concerning patterns of interaction between genders and how gender is enacted (Connell, 2012). In less gender-sensitive settings, this may mean not interjecting with gender concerns or questioning how gender aware a task or project is, as evidenced by HC member describing an event for National Women's Day:

> "We had a big modelling show here where we had like, it was held on Women's Day, where the queen arrived on the bakkies [pick-up trucks]... and we drive down to the other hall there" [HC3CM1]

The misalignment of such an event with gender rights conveys how HCs can be unreflective of gender inequality and the impact of oppressive norms on women's and SOGI minorities' health. The lack of consistent gender-sensitivity training or awareness of gender specifics in health means that HCs are not trained to be critical of services and how they accommodate gender. This presents a challenge to pursuing any substantive gender mainstreaming in which healthcare staff or representatives should incorporate the varying experiences, health requirements and status of different genders (Donner, 2005). HCs should self-reflect on issues such as gender equality and oppressive norms to help allay myths and stereotypes about gender and sexuality in their structures, work, and larger communities.

Misalignment of Gender Concepts

In asking how gender plays into the HC's work, gender as an issue was never outright rejected as being an important consideration in health, but questions about gender equality, gender and leadership or gender and health were routinely missed or answers relating to other current committee concerns were offered instead. Planning, discussion and strategising was repeatedly observed without any gender perspectives, removed from any gender mainstreaming integration (McNutt, 2010). Gender was considered in terms of practical considerations dealt with by HCs such as increased security when walking with men in public, or socio-cultural aspects of older Muslim male community members preferring not be assisted by young female HC members. However it also appeared that gender was sometimes conflated with sexuality, albeit with sympathetic attitudes:

> Interviewer: "…does the gender of the person or people you're dealing with change how you do your work?"
>
> Respondent: "I don't think it's, no because with the gay community, they are so open-minded." [HC2CM3]

This conflation was not challenged by other HC members during the group session in which it occurred. Gender and sexuality appear to be loosely understood and linked, as an afterthought to health. HC members are eager to report that gender has no effect on their work as gender-neutral service is assumed to mean equality, but this is also erroneously understood to encompass equity, which impinges on inclination and goal setting for gender mainstreaming outcomes (McNutt, 2010). There was nothing to contradict that sexual and gender minorities are accepted abstractly, while gender and sex are understood as a binary in real terms. This has massive implications for sexual and gender minorities seeking basic health services in their communities, where respect and acceptance are vital for accessible and acceptable health care practice (Snowdon, 2013).

Perceptions of Gender Roles

Of the three HCs covered in the study, one had two male committee members, another had one male committee members and one was exclusively women. Female committee leaders and health facility managers were not undermined, but credence was given to male leadership as something highly desired:

> "I think maybe the men will give us advice on some stuff that we do, and I think that we will be stronger if we had men in this health committee." [HC3CM1]

> "And you know when women get together there's always problems, but I think if a man is there they can teach us a lot." [HC1CM2]

This mimics insights from Mohanty's 2002 work on barriers to women in participation, who are often saddled with implementation in the face of official male bias and social reservations about

women's capacities. The mythic value placed on male leadership and participation is compounded by the difficulty HCs experience attracting men to join up, which HC members attribute to lack of will or availability:

> "...it's mostly women, because men have to go out and work. I would assume most men are out there working." [HC1KI1]

> "Most of the youngsters like the men, is sitting on the corners, doing drugs or whatever they do... I think they're not much interested in it, because it's voluntary, we don't get paid."[HC1CM3]

The assumption of male leadership as an expectation among HC members reflects gender relations being a construction of social relations (Connell, 2012). The persistent dominance by men is an unchallenged standard despite its practical irrelevance and lacking will of men. Participation bodies may be mediated by existing social dynamics in homes and communities which are not confronted, neutralised or dismantled despite democratic precepts (McEwan, 2005).

Gender and Power Dynamics

One distinguishable setting revealed how the reliance on gender norms could also be leveraged to promote committee legitimacy. A committee member of an otherwise all female committee indirectly described how their male chairperson was elected despite not displaying strong leadership qualities, purely out of social expectation:

> "Sometimes people would, maybe, elect a chairperson based on the fact that he's a male and it's this concept of males are strong and... disciplined, which is sometimes not the case, but it's the fact that he's a male, they will elect

> you and make you chairperson... but it's this view of what a man should be all about that makes them vote for this person." [HC2CM6]

The chairperson, who was often absent from meetings and displayed little to no prominence otherwise, expressed the desire to leave the HC several times but had been pressured to stay. Fellow HC members explained that, along with most HCs, they struggle to recruit male HC members due to lacking incentives, being men prone to joining gangs, which provide more "rank" in the area. This inclination towards rank and a reluctance to be led by women was outlined by a sub district manager:

> "...the moment they see there's a committee or a group and it's mostly women and they're taking charge, they [the men] mostly step back a bit. It's only a few men that will stick around... in [area], rank and roles is very, it's something big, especially because it's a like a star to your name." [HC2KI1]

Nevertheless, gender dynamics remain an uncontested, subtle force with which HC members contend. From a member of the same committee above:

> "...in terms of the health committee as it is, I don't think gender skews the roles and stuff like that." [HC2CM6]

In addition to no training on gender equality and gender and health, coaching around organising committee formalities in HCs is inconsistent. Meetings are the exception, which run around an agenda where all members may freely contribute to any discussion, with votes taken to settle disputes. It was observed that a flat, communal power dynamic tends to shift once a man is present, as the group will turn to the man as a spokesperson or bestow leadership roles upon them. All past

or present male members of HCs observed had occupied some kind of leadership role, despite many of the women's own social networks or popularity in the community. Established elder female HC members with social capital due to years of social upliftment work, tended to not secure or attempt to secure status, with some appealing to newer and younger members to carry the torch.

This perceived correlation between male leadership and legitimacy signifies prevailing notions of limited agency on the part of women and other marginalised groups (McEwan, 2005). The leveraging of gender roles incurred by the female HC members does not result in an overemphasis on women's health but could be an act of security in compensation for their resource capital (employment, ability to secure resources) to bolster the man's rank in accordance with social and gender role expectations, and therefore legitimise the HC's community reputation. These deeply instilled norms may require the intervention of human resource monitoring (McNutt, 2010) to assist committees in dismantling disingenuous nexuses of power which impede full participation of community actors.

Limitations

The study was limited to observations and perceptions of HC members and a few other parties, and could be broadened to fully incorporate those of facility managers, ward councillors, community members and other role-players connected to HCs, to reflect a more comprehensive local context. This could also include local gender activist NGOs to assist in providing a framing of gender and health access and governance in the Province, particularly for SOGI. The sample size, geographical scope, restricted number of observation sessions together with the exclusion of languages other than English and Afrikaans narrowed the scope of the study such that it may not be truly representative of all HCs in the Western Cape. While care was taken to avoid jargon, it seems possible that a

disconnect may have existed between the researcher's and participants' interpretation of terms employed. Simple and direct experiential questions of gender as it arises in the HC's work using-gender-sensitive language may have been more effective. Time invested in establishing common ground with respect to language early in the project could have permitted a fuller exploration of committee dynamics in the data collection process. Misunderstanding or uncertainty regarding the questions' intent may have inhibited participants' disclosure such that the full extent of their experiences informing some complexities of the study may have been missed. Given time and resources, member checking would ideally be employed to confirm the participants' responses and allow the opportunity to address any possible misrepresentation.

Conclusions

The role of gendered power relations in health committees in the Western Cape is foreseeably manifold. Within Connell's theory, gender relations persist with notions of power being conferred to men or shared by women rather than a woman or any gender minority owning powerful roles. Labour and extensive cathexis are the domain of women in HCs as caregivers and custodians without titles. Gender equality in health – as found in legislation such as the Constitution of South Africa, the 2013 WEGE Bill, National Department of Health (2011) and related policy – needs to be effectively operationalised at facility level. Gender-sensitivity training is necessary of HCs and health workers are to respond adequately to sexual and gender minorities in their communities, and to acknowledge gender issues within their own functioning and priorities. This should occur in a broader context which supports gender-based analysis and gender-transformative health programming as part of an ongoing development paradigm in which normative gender roles are challenged and support is provided for women and gender minorities to participate in health governance structures.

The African feminist lens provides that African women and SOGI in HCs navigate multiple oppressions, which are not personally mitigated by their activity in HCs but their presence on HCs is still vital. “Status” due to HC involvement is minimal and does not convey privilege, and as the research process demonstrated, these groups are vulnerable to continual misrepresentation. Findings also affirm that challenges remain for the full enjoyment of participation rights as a function of citizenship for women and SOGI as these rights are continuously shaped by social and gender inequality in their communities and in relation to local power structures. HC governance roles need to be ratified by policy with increased ability to influence decisions to empower members in their monitoring and accountability capacities, including those for SOGI minorities. The Western Cape Health Facility Boards and Committees Act 2016 broadly outlines HC nomination and jurisdiction and has since provided that HCs may fundraise, conduct surveys, request routine information regarding their health facilities, disseminate this to their communities and make recommendations to facility managers, municipalities and the Provincial Minister. This is a progressive step towards influencing relevant mandates and upscaling community needs with HC input, which recognises and furthers HC modalities of active citizenship.

Gender-based analysis of these findings suggest that further exploration of the gender-sensitivity of participatory structures or their ability to effect gender mainstreaming in other contexts is needed. Gendered power relations may account for low representation of women and SOGI minorities on health facility governing committees – as was seen in Tanzania (Frumence et al., 2014). Unexplored gender biases may underlie poor governance of Gender policy implementation, as seen in village development committees in Nepal (Devkota et al., 2013).

There are important implications for public health policy such as the 2016 Act around gender mainstreaming and require further research on a national scale. Capacity-building for community participants and healthcare staff has to be incorporated within gender-mainstreaming processes. These processes must not financially burden members to ensure full compliance, especially in low

resource settings. Inclusion and representation on HCs has to be instrumental through equitable recruitment and involvement of women and SOGI minorities in decision making – and not merely tokenistic. The new Act decrees that HC membership should be gender-sensitive, but evidently this requires elaboration with ongoing committee and facility training and guidelines to instill the missing impetus of gender in health and cater for the specific needs of women and SOGI minorities. Linkages between HC members and their respective ward councillors must be strengthened with monitored engagement to negate political distrust and enact the duties stipulated by the Act, and bolster HCs as accountability structures.

References

Abu-Duhou, J., Liping, Y, and Manderson, L. (2003). Gender sensitivity and gender-based analysis in women's health development; historical outlines and case studies of best practice. Kobe, Japan: World Health Organisation

African Commission in Human and People's Rights (1995). Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa.

African Commission in Human and People's Rights (2014). Resolution 275: Protection against Violence and other Human Rights Violations Against Persons on the Basis of their Real or Imputed Sexual Orientation or Gender Identity.

Bowleg, L. (2012). The problem with the phrase *Women and Minorities*: Intersectionality – an important theoretical framework for public health. *American Journal of Public Health,* **102**(7), pp. 1267-1273.

Chamberlain, L. (2016). Assessing enabling rights: Striking similarities in troubling implementation of the rights to protest and access to information in South Africa. *African Human Rights Law Journal,* **16**(2), pp. 365-384.

Connell, R.W. (1987). *Gender and Power: Society, the Person and Sexual Politics*. Stanford, CA: Stanford University Press

Connell, R. (2012). Gender, Health and Theory: Conceptualising the issue, in local and world perspective. *Social Science & Medicine,* **74,** pp.1675-1683

Cooper, D., Morroni, C. Orner, P., Moodley, J. Harries, J. Cullingworth, L. and Hoffman, M. (2004) Ten years of Democracy in South Africa: Documenting Transformation in Reproductive health policy and status. *Reproductive Health Matters* **12**(24) pp. 70-85.

Cornwall, A. (2003). Whose voices? Whose choices? Reflections on Gender and Participatory Development. *World Development*, **31**(8), pp. 1325-1342.

Department of Health (2004). *South Africa National Health Act No. 61 2003*. Government Gazette No. 26595 South Africa.

Devkota, S. and Upadhyay, M. (2013). Agricultural productivity and poverty reduction in Nepal. *Review of Development Economics,* **17**(4), pp. 732-746.

Donner L. (2005). Including Gender in Health Planning: A Guide for Regional Health Authorities. Winnipeg, MB: Prairie Women's Health Centre of Excellence. 47p. [Online] Available at: http://www.pwhce.ca/gba.htm [Accessed: 5 July 2014].

Dunkle, K.L., Jewkes, R.J., Brown, H.C., Gray, G.E., McIntyre, J.A., and Harlow, S.D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet,* **363**(9419), pp. 1415-1421.

Frumence, G., Nyamhanga, T., Mwangu, M. and Hurtig, A-K (2014). Participation in health planning in a decentralised health system: Experiences from facility governing committees in the Kongwa district of Tanzania. *Global Public Health,* **9**(10), pp. 1125-1138.

Goredema, R. (2010). African Feminism: the African woman's struggle for identity. Yearbook Section 4 pp. 33-41.

Gouws, A. (1996). Feminist Epistemology and Representation: The Impact of Post-Modernism and Post-Colonialism. *Transformation,* **30**(1996), pp. 65-82.

Gruskin, S. and Ferguson, L. (2013). Using health indicators to determine the contribution of human rights to public health efforts. Ch. 13. *In* Grodin, M.A., Tarantola, D., Annas, G.J. and Gruskin, S. (Eds.) *Health and Human Rights in a Changing World*. New York, NY: Routledge.

Haricharan, H. (2012). Extending Participation: Challenges of Health Committees as meaningful structures for community participation. Learning Network for Health and Human Rights. Available at: http://www.salearningnetwork.uct.ac.za/sln/publications/other-reports [Accessed 14 April 2014].

Haricharan, H. (2013). Rapid Appraisal of Health Committees policies in South Africa. Learning Network for Health and Human Rights. Available at: http://www.salearningnetwork.uct.ac.za/sln/publications/other-reports [Accessed 14 April 2014].

Kautzky, K., and Tollman, S.M. (2008). A Perspective of Primary Health Care in South Africa. *South African Health Review,* 2008(1), pp. 17-30.

Lehmann, U. and Gilson, L. (2013). Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health Policy and Planning,* **28**(4), pp. 358-366.

Loewenson, R., Rusike, I. and Zulu, M. (2004). The Impact of Health Centre Committees on health outcomes in Zimbabwe. (Paper Presentation). Forum 9, Global Forum for Health Research. Mumbai, September 2005.

Logie, C. (2012). The case for the World Health Organization's Commission on the Social Determinants of Health to address sexual orientation. *American Journal of Public Health*, **102**(7), pp. 1243–1246.

London, L. (2008). What is a human-rights based approach and why does it matter? *Health and Human Rights Journal,* **10**(1), pp. 65-80.

Mayer, K.H., Bradford, J.B., Makadon, H.J., Stall, R., Goldhammer, H., and Landers, S. (2008). Sexual and gender minority health: what we know and what needs to be done. *American Journal of Public Health,* **98**(6), pp.989–995.

Maluka, S. O. and Bukagile, G. (2016). Community participation in the decentralised health systems in Tanzania: why do some health committees perform better than others? *The International Journal of Health Planning and Management,* **31**(2), pp. E86-E104.

McCoy, D.C., Hall, J.A. and Ridge, M. (2012). A systematic review of the literature for evidence on health facility committees in low-and middle- income countries. *Health Policy and Planning,* **27**(6), pp. 449-466.

McEwan, C. (2005). New spaces of citizenship? Rethinking gendered participation and empowerment in South Africa. *Political Geography,* **24**(6), pp. 969-991.

McNutt, K. (2010) An Integrated Approach to Gender Equality: From Gender-Based Analysis to Gender Mainstreaming. Johnson-Shoyama Graduate School of Public Policy Working Paper Series. University of Saskatchewan, Canada. February, Issue 2 pp. 1-13.

Mohanty, R. (2002). Women's participation in JFM in uttaranchal villages, Mimeograph. In Cornwall, A. (2003). Whose voices? Whose choices? Reflections on Gender and Participatory Development. *World Development*, **31**(8), pp.1325-1342.

Müller, A. and Hughes, T. L. (2016). Making the invisible visible: a systematic review of sexual minority women's health in Southern Africa. *BMC Public Health*, **16**(307) [Online] Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-2980-6 [Accessed 15 February 2017].

Republic of South Africa, Department of Health. (2011). Sexual and Reproductive Health Rights: Fulfilling our Commitments 2011-2021 and Beyond.

Newman, C. (2014). Time to address gender discrimination and inequality in the health workforce. *Human Resources for Health,* **12**(25), pp. 1-11.

Pega, F. and Veale, J.F. (2015). The case for the World Health Organization's Commission on Social Determinants of Health to address gender identity. *American Journal of Public Health*, **105**(3), e58–e62.

Petchesky, R. (2003). *Global Prescriptions: Gendering Health and Human Rights.* London: Zed Books.

Republic of South Africa. Constitution of the Republic of South Africa No. 108 of 1996. Available at: http://www.gov.za/documents/constitution/constitution-republic-south-Africa-1996-1 [Accessed 7 January 2017].

Republic of South Africa. Women Empowerment and Gender Equality Bill 2013. Available at: http://www.gov.za/documents/women-empowerment-and-gender-equality-bill-0 [Accessed 14 February 2017].

Robson, C. (2011) *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* 3rd Ed Oxford, UK: Blackwell Publishers Ltd.

Saiz, I. (2004). Bracketing sexuality: Human rights and sexual orientation – a decade of development and denial at the UN. *Health and Human Rights,* **7**(2), pp.49-80.

Scully, P. (2009). Should we give up the State? Feminist Theory, African gender history and transitional justice. pp. 29-43.

Snowdon, S. (2013). Equal and respectful care for LGBT patients. The importance of providing an inclusive environment cannot be underestimated. *Healthcare Executive,* **28**(6), pp. 52-55.

South African Human Rights Commission. (2009). Public Inquiry: Access to health care services. Available at: unpan1.un.org/intradoc/groups/public/documents/cpsi/unpan034902.pdf [Accessed 1 March 2017].

Stevens, M. (2012). *Transgender Access to Sexual Health Services in South Africa.* Gender Dynamix. Available at: https://genderdynamix.org.za/documents/transgender-access-to-sexual-health-services-in-south-africa/ [Accessed 7 January 2017].

The Legal Resources Centre, Iranti-org, and Gender Dynamix. (2016). ACHPR Transgender and Intersex Shadow Report April 2016. Available at: https://genderdynamix.org.za/documents/achpr-transgender-and-intersex-shadow-report-april-2016/ [Accessed 1 March 2017].

Tandon, R. (2002). Linking citizenship, participation and accountability: A perspective from PRIA. *IDS Bulletin,* **33**(2), pp. i-viii.

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, Available at: http://www.refworld.org/docid/4538838d0.html [Accessed: 14 May 2014].

UNDP (2013). Discussion Paper. Transgender Health and Human Rights. United Nations Development Programme HIV Health and Development Group, Bureau for Development Policy, New York, USA

UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13, Available at: http://www.refworld.org/docid/3ae6b3970.html [Accessed 23 June 2017].

UN Human Rights Council (2011). Resolution 17/19 Human rights, sexual orientation and gender identity. United Nations General Assembly, New York

UNICEF Bangladesh. (1993). Visualisation in Participatory Programmes: A manual for facilitators and trainers involved in participatory group events. New York: Programme Communication and Information section, UNICEF Bangladesh

Western Cape Department of Health. Draft Western Cape Health Facility Boards and Committees Bill, 2015. Available at: https://www.westerncape.gov.za/news/extension-notice-period-comment-health-facility-boards-and-committees-bill [Accessed 15 February 2017].

Western Cape Provincial Parliament. Western Cape Health Facility Boards and Committees Act, 2016. Available at: http://wcpp.gov.za/legislation [Accessed 22 December 2016].

Wieringa, S. (1998). Rethinking Gender Planning: A critical discussion of the use of the concept of gender. Institute of Social Studies, The Hague. (Working Paper No. 279).

WHO (2015). *Sexual Health, Human Rights and the Law.* Geneva: World Health Organisation

Afterword

Following the commencement of the fieldwork, there were a few instances in which the research digressed from the proposal.

Sampling and recruitment were convenience and self-selection, however the actual respondent sample was not as large as first anticipated. Fieldwork progressed by starting with meeting observations, followed by inviting respondents to have a group discussion if feasible, and then inviting some of the members to have in-depth interviews. Fieldwork at the three sites did not always neatly overlap, meaning that early saturation in in-depth interviews lead to fewer respondents being recruited. Therefore the proposed five respondents were interviewed from two of the sites, however only three were recruited from the third site due to saturation of data at that point. A group discussion was only feasible with one committee. This was also coupled with logistical constraints as some respondents were simply unavailable for interviews due to other commitments.

The Health Committees were also found to have extremely minimal documentation practices, therefore documentation review of this material was not pursued.

Part D: Appendices

APPENDIX A

Topic Guide for Key Informant interviews

1) What is the role of Health Committees (HCs) in realising the Right to Health?
2) What do HCs do to uphold non-discrimination?
3) What kind of power dynamics have you observed in HCs?
4) How do HCs set their goals and priorities?
5) How does gender feature in Health Committees? What is the awareness of Gender-sensitivity in addressing issues and providing services?
6) Other possible key informants
7) Access to Health Committees

Topic Guide for In-depth interviews of Health Committee members

1) Description of the Health Committee
2) The role of the HC in realising the right to health
3) What is your understanding of equality and non-discrimination? How does the HC follow this?
4) What do you think influences the goals and decisions made by the HC? Is this always effective?
5) Where do you think the priorities should be and have you made this known? Why/why not?
6) Perception of gender relations within the HC
7) How do you think health care needs are different for different genders?
8) How do you think the HC committee recognises the needs of the genders?

APPENDIX B

Information Sheet

Study: Gender and Power in Health Committees in the Cape Metro

Greetings, and thank you for your time today. My name is Janet Austin and I am a student at the University of Cape Town.

You are being invited to participate in a research project that is looking at Health Committees and gender and power in Health Committees. The research is part of my Masters' degree in Public Health at the University of Cape Town. It is also part of the bigger European Union funded project with the Learning Network about understanding how health committees work and the training programme with health committees. Here is some more information about the research and what it will mean if you agree to take part in the research.

Why is this research being done?

Health Committees play an important role in meeting the health needs in local communities. There are many factors that affect the working of Health Committees and the study wants to see how the understanding of gender and different power relationships are part of this. For Health Committees to be equal and non-discriminatory, there should be fairness in the way that a committee works, and an understanding of the different needs of all genders, with all being seen as important. The study will explore how much of this is happening in Health Committees and what can be done to improve it.

What is the aim of the research?

To learn about:

- How Health Committees work and the different roles in Health Committees
- The perception of gender in health committees
- How gender influences Health Committee roles and functions
- How gender influences the health issues taken up by health committees

What research methods will be used?

1) A group discussion using diagrams
This will be a group discussion with Health Committee members. The meeting will be at a time and place that is good for everyone. Some things we will discuss together will include how members understand the needs of their community, how goals are set in the committee and how members get to participate in committee decision-making. I would like ask if I could audio-record this discussion for accurate records for the research, with which the group can agree or disagree.

2) Interviews
This will be with you on your own, to talk in more detail about your experience of being part of a health committee. I may want to ask you about topics such as what you think influences the way the committee runs and how well you think the different needs of the members are handled. I would like to ask if I could audio-record the interview for accurate records for the research, with which you can agree or disagree.

3) Observations
I will ask permission to join Health Committee meetings to see and hear what happens at meetings.

What am I asking from you?

You are being invited to take part in the group discussion, possible individual interview and a meeting observation. You do not have to take part in all of these research activities.

How much time will it take?

Group interview: 2-3 hours (refreshments will be served)
Interviews: about 1 hour

What are the benefits of participation?

There are no direct benefits to you. But this study will help us to learn about and understand how Health Committees work and how things could potentially work better. We will pass this learning on to other Health Committees and to policy makers.

What are the risks of participating?

There should be no risks for you in participating in the research. However, if you find any of the topic upsetting, you can let me know, or you can contact my supervisor or you can contact or someone from the Cape Metro Health Forum.

What will happen to the information collected?

Your name will not be used and the information you give to me will be carefully stored, not to be shared with anyone outside of the research team. I will write a summary report for the Health Committees and for the bigger Learning Network work project. I will also publish a paper about my findings.

If you have any questions about the research you can contact me on:

Cell: 072 2282516
Email: astjan006@uct.ac.za

Consent Form

Gender and Power Relations in Western Cape Health Committees.

Now that you have read the Information sheet, I am asking if you are happy to participate in the research.

You do not have to participate in the research.

You can choose to stop participating in the research at any time. You can choose to stop an interview or leave a group discussion at any time. You do not have to give a reason for this.

If you decide not to participate in the study it will not affect your participation in the Health Committee or any services you receive.

Interviews will be organised at a time and place that is good for you. You can choose which language you want to speak.

Your name will not be recorded anywhere. Information will be shared with other people from the research team and will be used in a report and a paper and your name will not be on any of these.

Do you have any questions you would like to ask me?

Contact for additional information:

Janet Austin (Masters Student in Public Health and Researcher)
Tel: 072 2282516
Email: astjan006@uct.ac.za

If you have any questions or concerns about your rights or welfare as a participant but do not want to ask me, you can contact:

Dr Alexandra Muller (Supervisor – UCT)
Tel: 021 406 6021
Email: alexandra.muller@uct.ac.za

Questions or concerns for the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC):

Lameez Emjedi Tel: 021 406 6524

If you would like to participate, please fill in this form (Please circle Yes or No):

I,_____(name) have read the information sheet and any questions I have been explained to me. I understand what the study is about and what is expected of me.

I agree to take part in a group discussion with other members of the Health Committee
Yes No

I agree to be contacted to be asked for an individual interview Yes No

I agree for the researcher to join the Health Committee meeting Yes No

I agree for written notes to be taken: Yes No

I agree for the group discussion to be audio-recorded: Yes No

I agree for the interview to be audio-recorded: Yes No

Participant: _____
(Signature)

Researcher: _____
(Signature)

Date: _____

APPENDIX C

Information Sheet for Key Informant interviews

Study: Gender and Power in Health Committees in the Cape Metro

Greetings, and thank you for your time today. My name is Janet Austin and I am a student at the University of Cape Town.

You are being invited to participate in a research project that is looking at Health Committees and gender and power in Health Committees. The research is part of my Masters' degree in Public Health at the University of Cape Town. It is also part of the bigger European Union funded project with the Learning Network about understanding how health committees work and the training programme with health committees. Here is some more information about the research and what it will mean if you agree to take part in the research.

Why is this research being done?

Health Committees play an important role in meeting the health needs in local communities. There are many factors that affect the working of Health Committees and the study wants to see how the understanding of gender and different power relationships are part of this. For Health Committees to be equal and non-discriminatory, there should be fairness in the way that a committee works, and an understanding of the different needs of all genders, with all being seen as important. The study will explore how much of this is happening in Health Committees and what can be done to improve it.

What is the aim of the research?

To learn about:

- How Health Committees work and the different roles in Health Committees
- The perception of gender in health committees
- How gender influences Health Committee roles and functions
- How gender influences the health issues taken up by health committees

What research methods will be used?

1) Key Informant interviews
This will be interviews with the first points of contact with the health committee, Learning Network members associated with the committee, or anyone who has a special interest in the committee's

activities. We will discuss the committee and some of the challenges it has faced and what drives the work it does.

2) A group discussion using diagrams
This will be a group discussion with Health Committee members. The meeting will be at a time and place that is good for everyone. Some things we will discuss together will include how members understand the needs of their community, how goals are set in the committee and how members get to participate in committee decision-making. I would like to ask if I could audio-record this discussion for accurate records for the research, with which the group can agree or disagree.

3) Interviews
This will be with you on your own, to talk in more detail about your experience of being part of a health committee. I may want to ask you about topics such as what you think influences the way the committee runs and how well you think the different needs of the members are handled. I would like to ask if I could audio-record the interview for accurate records for the research, with which you can agree or disagree.

4) Observations
I will ask permission to join Health Committee meetings to see and hear what happens at meetings.

What am I asking from you?

You are being invited to be interviewed as key informant for your health committee. If you are a health committee member, you are also invited to take part in the group discussion, a meeting observation and a possible follow-up interview. You do not have to take part in all of these research activities.

How much time will it take?

Group interview: 2-3 hours (refreshments will be served)
Interviews: about 1 hour

What are the benefits of participation?

There are no direct benefits to you. But this study will help us to learn about and understand how Health Committees work and how things could potentially work better. We will pass this learning on to other Health Committees and to policy makers.

What are the risks of participating?

There should be no risks for you in participating in the research. However, if you find any of the topic upsetting, you can let me know, or you can contact my supervisor or you can contact or someone from the Cape Metro Health Forum.

What will happen to the information collected?

Your name will not be used and the information you give to me will be carefully stored, not to be shared with anyone outside of the research team. I will write a summary report for the Health

Committees and for the bigger Learning Network work project. I will also publish a paper about my findings.

If you have any questions about the research you can contact me on:

Cell: 072 2282516
Email: astjan006@uct.ac.za

Consent Form for Key Informant Interviews

Gender and Power Relations in Western Cape Health Committees.

Now that you have read the Information sheet, I am asking if you are happy to participate in the research.

You do not have to participate in the research.

You can choose to stop participating in the research at any time. You can choose to stop an interview or leave a group discussion at any time. You do not have to give a reason for this.

If you decide not to participate in the study it will not effect your participation in the Health Committee or any services you receive.

Interviews will be organised at a time and place that is good for you. You can choose which language you want to speak.

Your name will not be recorded anywhere. Information will be shared with other people from the research team and will be used in a report and a paper and your name will not be on any of these.

Do you have any questions you would like to ask me?

Contact for additional information:

Janet Austin (Masters Student in Public Health and Researcher)
Tel: 072 2282516
Email: HYPERLINK "mailto:astjan006@uct.ac.za"astjan006@uct.ac.za

If you have any questions or concerns about your rights or welfare as a participant but do not want to ask me, you can contact:

Dr Alexandra Muller (Supervisor – UCT)
Tel: 021 406 6021
Email: alexandra.muller@uct.ac.za

Questions or concerns for the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC):

Lameez Emjedi Tel: 021 406 6524

If you would like to participate, please fill in this form (Please circle Yes or No):

I,_____(name) have read the information sheet and any questions I have been explained to me. I understand what the study is about and what is expected of me.

I agree to be contacted to be asked for an individual interview Yes No

If you a health committee member:

I agree to take part in a group discussion with other members of the Health Committee Yes No

I agree for the researcher to join the Health Committee meeting Yes No

I agree to be contacted to be asked for a possible further individual interview Yes No

I agree for written notes to be taken: Yes No

I agree for the group discussion to be audio-recorded: Yes No

I agree for the interview to be audio-recorded: Yes No

Participant: _____
(Signature)

Researcher: _____
(Signature)

Date: _____

APPENDIX D

Diagramming and Visualisations Group discussions

The group discussion section of the data collection will take place in the form of Visualisation in Participatory Programmes (VIPP), a people-centred methodology for conducting group discussions using symbols or colourful cards to represent ideas (Salas, et al. 2007). This falls under the Participatory Learning Action framework which incorporates drawings and group discussions, whereas VIPP is only applicable to literate groups. It can be used in multiple contexts, such as training, putting research into action, planning and development work. The method itself refers to using materials such as flipcharts, different colour cards, pin boards or other stationary to "visualise" concepts and ideas related to an overall theme, as opposed to abstracted presentations or pure discussion groups where some speakers tend to dominate to the detriment of other group participants (UNICEF Bangladesh, 1993).

The content and process for these methods in this study will involve deconstructing key themes of the right to health, power and gender. Open questions around each of these topics can produce categories suggested by each group member at their will, which are written on coloured paper and stuck on a large board for all to see. Links and mechanisms between these topics can be visualised using different shapes or coloured paper, for example "mistrust" written on a red square may represent a barrier to "communication" or "equality" or another relevant goal written on a blue rectangle. The result is a diagram of theme paradigms or processes at work in the group or around the issue in question. The facilitator may have a skeleton of topics or probing questions around these topics, whilst group produces the content and can thereby steer the discussion.

APPENDIX E

Health Policy and Planning

Instructions for Authors

Health Policy and Planning's aim is to improve the design and implementation of health systems and policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. HPP is published six times a year.

HPP has a double-blinded peer-review policy. All papers, in each of the categories described below, are peer reviewed.

Specific objectives are to:

- Attract high quality research papers, reviews and debates on topics relevant to health systems and policies in low- and middle-income countries;
- Ensure wide geographical coverage of papers including coverage of the poorest countries and those in transition;
- Encourage and support researchers from low- and middle-income countries to publish in *HPP* ;
- Ensure papers reflect a broad range of disciplines, methodologies and topics;
- Ensure that papers are clearly explained and accessible to readers from the range of disciplines used to analyse health systems and policies; and
- Provide a fair, supportive and high quality peer review process.

Health Policy and Planning welcomes submissions of the following types: original articles, review papers, methodological musings, research in practice, commentaries, and papers in our series 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

Authors should pay close attention to the factors that will increase likelihood of acceptance. As well as the high overall quality required for publication in an international journal, authors should address HPP's readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health systems and policy issues and debates in low- and middle-income countries. Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected or returned to the authors for redrafting prior to being reviewed. In addition, economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.

Public health specialists writing about a specific health, policy, challenge or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made.

Manuscripts must be submitted online. Once you have prepared your manuscript according to the instructions below please visit the online submission website . Instructions on submitting your manuscript online can be viewed here .

Manuscripts containing original material are accepted for consideration with the understanding that neither the article nor any part of its essential substance, tables, or figures has been or will be published or submitted for publication elsewhere. This restriction does not apply to abstracts or short press reports published in connection with scientific meetings. Copies of any closely related manuscripts should be submitted along with the manuscript that is to be considered by *HPP. HPP* discourages the submission of more than one article dealing with related aspects of the same study.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com

During the online submission procedure, authors are asked to provide: a) information on prior or duplicate publication or submission elsewhere of any part of the work; b) a statement of financial or other relationships that might lead to a conflict of interest or a statement that the authors do not have any conflict of interest; c) a statement that the manuscript has been read and approved by all authors (see also section on authorship below); d) the name, address, telephone and fax number of the corresponding author who is responsible for negotiations concerning the manuscript. The manuscript must be accompanied by copies of any permissions (see heading Permissions below) to reproduce already published material, or to use illustrations or report sensitive personal information about identifiable persons.

All papers submitted to HPP are checked by the editorial office for conformance to author and other instructions all specified below. Non-conforming manuscripts will be returned to authors.

PRE-SUBMISSION LANGUAGE EDITING

If your first language is not English, to ensure that the academic content of your paper is fully understood by journal editors and reviewers is optional. Language editing does not guarantee that your manuscript will be accepted for publication. For further information on this service, please click here. Several specialist language editing companies offer similar services and you can also use any of these. Authors are liable for all costs associated with such services.

AUTHORSHIP

All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors. Each author should have participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based on substantial contribution to conception and design, execution, or analysis and interpretation of data. All authors should be involved in drafting the article or revising it critically for important intellectual content, must have read and approved the final version of the manuscript and approve of its submission to this journal. An email confirming submission of a manuscript is sent to all authors. Any change in authorship following initial submission would have to be agreed by all authors as would any change in the order of authors.

SUBMISSION

Please read these instructions carefully and follow them closely to ensure that the review and publication of your paper is as efficient and quick as possible. The Editorial Office reserve the right to return manuscripts that are not in accordance with these instructions.

All material to be considered for publication in Health Policy and Planning should be submitted in electronic form via the journal's online submission system. Once you have prepared your manuscript according to the instructions below, instructions on how to submit your manuscript online can be found by clicking here.
Return to top of page.

MANUSCRIPT TYPES AND PREPARATION

- original articles
- review papers
- methodological musings
- research in practice
- commentaries
- papers in our series 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

ORIGINAL RESEARCH

Manuscripts should preferably be a maximum of 6000 words, excluding tables, figures/diagrams and references.

The **title page** should contain:

- Title - please keep as concise as possible and ensure it reflects the subject matter;
- Corresponding author's name, address, telephone/fax numbers and e-mail address;

- Each author's affiliation and qualifications;
- Keywords and an abbreviated running title;
- 2-4 Key Messages, detailing concisely the main points made in the paper;
- Acknowledgements
- A word count of the full article.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

In the **acknowledgements**, all sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material. Colour figures are permitted but authors will be required to pay the cost of reproduction.

All **measures** should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Statistics:

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Report simple analyses first, then only more sophisticated results.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (E.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as N (%), not just %.
- Report p values with 2 digits after the decimal, 3 if <0.01 or near 0.05. E.g., 0.54, 0.03, 0.007, <0.001, 0.048. Do not report p values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc)."

APPENDIX F

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

09 February 2015

HREC REF: 922/2014

Dr M Stuttaford
Public Health & Family Medicine
Falmouth Building

Dear Dr Stuttaford

PROJECT TITLE: GENDERED POWER RELATIONS AND PARTICIPATION: HEALTH COMMITTEES IN THE WESTERN CAPE. (LINKED TO STUDY OF 179/2007). (Masters candidate- Janet Austin)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 28th February 2016.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

We acknowledge that the student, Janet Austin will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH

2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI),and Declaration of Helsinki guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.